(ER: This certificate should be executed within 24 hours after death. If any delay is necessary, please the word "pending" in pendil in Item, 18. Give Pages 1, 2, and 3 to the funeral director. Pro-Chief Medical Examiner's Office along with form PM3. Page 5 may be relained for your filed. It should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or to burial, cremation, at remand, and in any ament within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5177MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| Reg. |       | 4   | 2 | 1 | 7 | 1 |
|------|-------|-----|---|---|---|---|
| Reg. | Dist. | No. | U | 7 |   | 1 |

|  | 3111   |                     |                                 |          |   |                        |   | Reg. D             | ist. No       | OT                             | . 7                |
|--|--|---------------------|---------------------------------|----------|---|------------------------|---|--------------------|---------------|--------------------------------|--------------------|
| 1. PLACE OF DE   | A11egany   |                     | MARYLA                          |          | O. STATE W. V                                     |                        | b. COUNT                                |                    | ence bef      |                                | ssion)             |
| and give nea   | WN (It outside corporate limits, write<br>est town)<br>rland   | EURAL C. LEN        | NGTH OF STAY IN                 | 16       | R. D. #   |                        |   | RURAL and          | give n        | parest tov                     | wn)                |
|  | ial Hosp.  | not in hospital, gi | . 1                             |          | d. STREET ADDRESS Short Ga                        | р                      |   |                    |               | ON.                            | A FARM?            |
| 3. NAME OF<br>DECEASED<br>[Type or print]  | First<br>JAME  | -                   | Middle<br>BLAINE                |          | AULT  | 4. DATE<br>OF<br>DEATH | Month                                   |                    | Doy           |                                | 9 58               |
| 5. SEX<br>Male   | 6. COLOR OR RACE White   | 7. MARRIED WIDOWED  | DIVORCED                        |          | y 1, 1898   |                        | 9. AGE (In years lest birthday) 60 yrs. | IF UNDER<br>Months | TYEAR<br>Doys | Hours                          | ER 24 HES.<br>Min. |
| Survey   | UPATION (Give kind of work d<br>working life, even if retired)<br>OP   |                     | Govit                           | DUSTRY   | Red Cree  |                        |   |                    |               | A.                             | COUNTRY            |
| 13. FATHER'S NA<br>Willi   | am A. Ault   |                     |                                 | 1        | . MOTHER'S MAIDEN N                               |                        | nner                                    |                    |               |                                |                    |
| 15. WAS DECEA! [Yes, no, et enknown]   | ED EVER IN U. S. ARMED FOR   | CES? 16. SOCIAL NO: |                                 |          | . Marie O.  | Au1t I                 | R. D. # 2                               | Keys               | er,           | W. 1                           | Va.                |
| PART  Light of the second of t | DUE TO  if ony, which immediate couse immediate couse immediate couse immediate couse immediate couse the underlying  DUE TO  (c). | Co                  | oronary                         |          | - м   |                        |   |                    |               | val setwe<br>v and dia<br>udde |                    |
| PART   | H. OTHER SIGNIFICANT CONE  | ONTRIBU             | ITING TO DEATH E                | BUT NO   | related to the termi                              | NAL DISEAS             | E CONDITION GIV                         | 'EN IN PAR         |               | PERFO                          | RMED?              |
| PRIMARY D  | or CONTRIBUTING 📑 📋  | DESCRIBE HOW        | INJURY OCCURRE                  | D. (Enle | r nature of injury in Port                        | I or Part II           | of item 18.)                            |                    |               |                                |                    |
| 20c. TIME O  |  | While               | OCCURRED 20e. Not while at work | PLACE    | OF INJURY (Home, form, street, office bldg., etc. | 20f. (City             | or fown)                                | (Cou               | inty)         |                                | (State)            |
|  |  | Skita               | X. Accide                       |          |   | domicide               |   | Inquir<br>rmined r | -             |                                | d in my            |
| 220. BURIAL, CRE<br>REMOVAL I<br>BULLIAL   | MATION, 22b. DATE THEREO Pecify) 5/15/58   | F                   | AME OF CEMETERS                 |          |   |                        | TION (City, town, o                     |                    |               | (State                         | e)                 |
|  | es L. George   |                     | nd, Mary:                       | land     |   | D BY REGIST            |   | STRAK'S SIC        | ich           | E                              |                    |

TO DEPUTY MEDICAL EXALCARE
SA execute the certificate, my
A should be farworded of the TO FUNERAL DIRECTOR: Poge 3

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designated

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| 7   | -   | 3         |   |             |
|---|---|-----------|---|-------------|
| TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 | 1   | pr,       | page 3 should be detached to use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with | (           |
| r death.  |   | funeral U | uld be fil  |             |
| ours afte   |   | in by the | ind 2 sho   |             |
| thin 24 h   |   | ly filled | Pages 3 c   |             |
| cuted wi  |   | complete  | sapers.   | oth.        |
| te be exe   |   | ion and   | corbon  | ofter de    |
| certifica   |   | ng physic | е гетоме  | 72 hours    |
| the death   |   | e ottendi | en pleos  | nl within   |
| res that  |   | hed by th | ermil. Th   | ony eve     |
| low requi   | ysician.  | been sigi | transit p   | ol, and it  |
| AN: The   | nding ph  | cate has  | he burial   | or remay    |
| PHYSICI   | for other   | A certif  | use as t  | ematian,    |
| ENDING  | he hase   | : Aft.    | oched for   | burial, cri |
| OR ATT  | may be retained by the hage to attending physician. | DIRECTO   | ld be det   | prior to    |
| DSPITAL   | r be retoi  | NERAL I   | e 3 shoul   | registrar   |
| TO H  | may   | TO FU     | Bod   | the         |

VS A15 (4) 1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5178 CERTIFICATE OF DEATH

Reg. Dist. No. 05172

| 1. PLACE OF DEATH o. COUNTY                                      | LEGANY  |               | MARY                          | LAND    | 2. USUAL RESIDEN                          | ARYL/      | ere deceased<br>AND | lived. If instit<br>b. COUN      |             | dence before |           | ion)              |
|--|---|---------------|-------------------------------|---------|---|------------|---------------------|----------------------------------|-------------|--------------|-----------|-------------------|
| RURAL and give r   | If autside corporate limits earest town)                | 1.1           | LENGTH OF STAY                | IN 1b   | c. CITY OR TOV                            |            |                     | ale limits, write                | RURAL or    | nd give nec  | rest towr | 1)                |
| d. NAME OF HOSPI<br>OR INSTITUTION                               | TAL (If not in haspital, given MEMORIAL HO              | re street odd |                               |         | d. STREET ADD                             | RESS       | RLAND               | STREET                           | r           |              |           | IDENCE<br>FARM?   |
| 3. NAME OF<br>DECEASED   | First   |               | Middle                        |         | Last                                      | ST WA      | 4. DATE             |                                  | lonth       | Da           |           | Yeor              |
| (Type or print)  | ALIC  | CE            | H.                            | •       | BE I GHT OL                               |            | DEATH               | 1                                | 4AY         |              | 22        | 19 58.            |
| 5. SEX<br>FEMALE   | 6. COLOR OR RACE  | 7. MARRIED    |                               | -       | B. DATE OF BIRTH OCTOBER                  | 311        | 384                 | 9. AGE (In year<br>lost birthdo) |             | DER 1 YEAR   | Hours     | R 24 HRS.<br>Min. |
| Oo. USUAL OCCUPATI   | ON (Give kind of work de<br>king life, even if retired) | one 10b. KIN  | ID OF BUSINESS C              |         | STRY 11. BIRTHPLAC                        |            |                     |                                  |             |              |           | COUNTRY           |
| Nouse  | >   | Hou           | se Wife                       | >       | RAWLI                                     |            |                     |                                  |             | U. S         | • A•      |                   |
| 13. FATHER'S NAME LYNN HUT                                       | SON   |               |                               |         | MAGGIE                                    |            |                     |                                  |             |              |           |                   |
|  | ER IN U. S. ARMED FORC                                  | ES? 16. SOC   | CIAL SECURITY NO              | 17. 1   | NFORMANT                                  | 2 110 1    | 3011                | A                                | ddress      |              |           |                   |
| (Yes, no, or unknown)  | (If yes, give wor or dates of ser                       | with)         | one                           |         | MEMORIAL                                  | HOSE       | PITAL               | - CUME                           |             | ND, M        | D.        |                   |
|  | immediate (   | 9,            | rora                          | 13      | ound of ar                                | Com        | ~~                  | lin                              |             |              | ERVAL BE  |                   |
| Z PART II. OT  | (c).  | ITIONS CON    | ITRIBUTING TO DE              | ATH BUT | NOT RELATED TO TH                         | IE TERMIN  | NAŁ DISEASE         | CONDITION                        | GIVEN IN F  | PART 1(a) 1  | 9. WAS    | AUTOPSY<br>PRMED? |
| PART II. 01  |   |               |                               |         |   |            |                     |                                  |             | -            |           | NO D              |
| # 20g. ACCIDENT W  | AS UNDERLYING DEATH AMEDICAL EXAMINER)                  | 20Ь. DESCRIE  | BE HOW INJURY O               | CCURRE  | D. (Enter noture of in                    | njury in P | ort I ar Port       | 11 of item 18.)                  |             |              |           | `                 |
| Y 20c. TIME OF INJU<br>Hour o. m.<br>p. m.                       | RY Month, Day, Year<br>19                               | While         | RY OCCURRED Not while of work |         | ACE OF INJURY (Hortory, street, office bl |            |                     | or town)                         |             | (County)     |           | (Stole)           |
| 21. I certify tolive on Actual SIGNATURE PHYSICIAN'S NAME (Type) | DR. GEORGE  | 12.5°         | 7                             | deoth   | occurred ot 8 s                           |            | M, from             | the couser<br>reet, city ar too  | s ond or    |              | te state  |                   |
| 220. BURIAL, CREMATIN<br>REMOVAL (Specify<br>BUTIAL              | ON, 226. DATE THEREOF                                   |               | 2c. NAME OF CEM               |         | R CREMATORY<br>metery                     |            |                     | ION (City, tow                   | n, or count | (Y)          | (Stol     | e)                |
| 23. FUNERAL DIRECTOR Byron B                                     |   |               | ADDRESS<br>Cumber             | Land    | 7 7                                       | ATEMAY     | BY REGIST           |                                  | GISTRAR'S   | SIGNATU      | RE        |                   |

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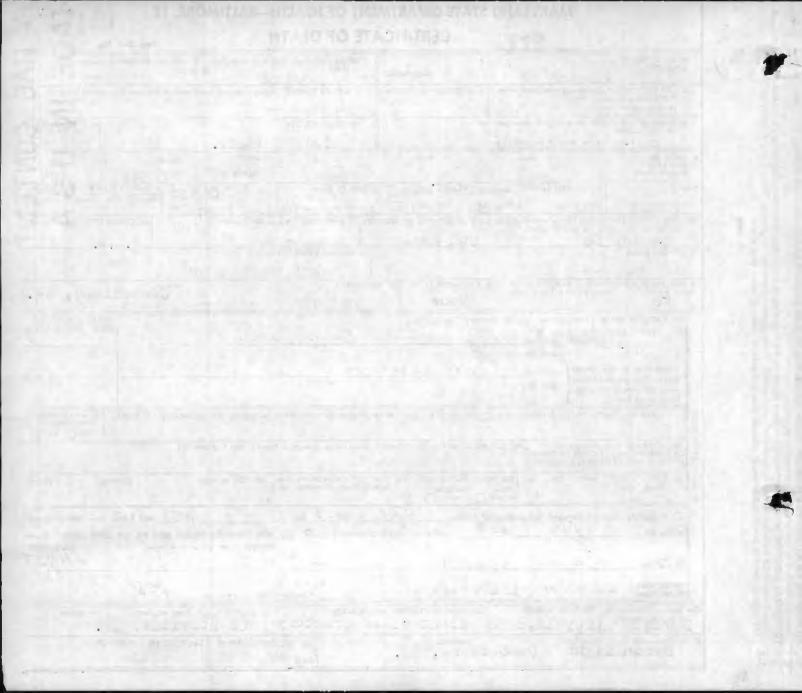
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05173 **CERTIFICATE OF DEATH** Reg. Dist. No. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission o. COUNTY o. STATE **b.** COUNTY MARYLAND ALLEGANY MARYT AND ALLEGANY CITY OR TOWN (If outside carporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) CUMBERLAND CUMBERT AND d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM? SACRED 300 BEDFORD ST YES NO HTART UNCOTTAL 3. NAME OF First Middle Lost 4. DATE Manth Day Year DECEASED (Type or print) DEATH MAY 9th 1958 BONIG 6. COLOR OR RACE S. SEX 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS Months Doys Hours Min. DIVORCED T WIDOWEDU DEMATE YES 100. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) during most of working life, even if retired) Housewife Own Home MARYT AND

14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME LIZZIE LOWENSTEIN JOHN SCHILLER IS. WAS DECEASED EYER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Cumberland, No None DAUGHTER EAMETTE RONTG 18. CAUSE OF DEATH [Enter only one couse per line-for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o)

lod 12. CITIZEN OF WHAT COUNTRY? **DUE TO** Conditions, if any, which gove rise to immediate **DUE TO** couse (a), stating the underlying cause lost (c). PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY 0 PERFORMED? YES NO 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) MEDICAL 20c. TIME OF INJURY 20e. PLACE OF INJURY (Hame, form, 20f. (City or tawn) Doy, Year 20d. INJURY OCCURRED (County) (Stote) foctory, street, office bldg., etc.) o. m. While Nat while at work of work p. m. 21. I certify that I attended the deceased from 19 Stat 1 last saw the deceased and that death accurred at 3:45 AM, from the causes and on the date stated above glive on ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) 220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City fown, (State) Grantsville Cemetery May Grantsville, 23. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 24a. REC'D BY REGISTRAR 246-REGISTRAR'S SIGNATURE Byron Kight Cumberland,

Ξ filled within lefely сошр eoth. puo 8 0 physicion COL 40 ottending ᇻ þ ony Ē ē.⊆ burial-transit peen attending pny certificote PHYSICIAN: 50 detoched Aff or FUNERAL DIRECTOR: A page 3 should be detach prior HOSPITAL he 0

O VS A15 (4) 15M 10/57



05174

| PLACE OF DEATH     O. COUNTY   | Allegany  | MA   | RYLAND             | 2. USUAL RESIDENCE<br>O. STATE                   | ce (Where december<br>aryland    |  | Afleg        |                | nission)             |
|--|---|--|--------------------|--|----------------------------------|--|--------------|----------------|----------------------|
| b. CITY OR TOWN  | (If outside corporate limits,<br>nearest town)                  | , write c. LENGTH OF STA                             | AY IN 16           | , _  | 'N {If outside corpo             |  | URAL and g   | ive nearest to | [nwc                 |
|  | rrelville   | 5 years  | 3                  |  | arrelvil                         | le   |              |                |                      |
| OR INSTITUTION   | TAL (If not in haspital, giv                                    | e street oddress)                                    |                    | d. STREET ADDR                                   | ESS                              |  |              |                | RESIDENCE            |
| At-  | llome   |  |                    | At Home  | e                                |  |              |                | □ NO 🔀               |
| 3. NAME OF<br>DECEASED<br>(Type or print)  | First   | WOODROW  |                    | GES.Jr.  | 4. DATE<br>OF<br>DEATH           | Mor  | ith<br>In Ca | Day            | Yeor<br>19 15-8      |
| 5. SEX   |   | MARRIED NEVER MAI                                    |                    | 8. DATE OF BIRTH                                 |                                  | P. AGE (In years                           | IF UNDER     | YEAR IS UN     | IDER 24 HRS.         |
| Male   | White   | WIDOWED DIVOR  | CED 🔲              | Anril 19.  | 1953                             | S yrs.                                     |              | Days Hou       |                      |
| 100. USUAL OCCUPATI<br>during most of wor  | rking life, even if refired)                                    | ne 10b. KIND OF BUSINESS                             | OR INDU            |  | (Stote or foreign o              |  | 12. CITI:    | USA            | AT COUNTRY           |
| 13. FATHER'S NAME  |   |  |                    | 14. MOTHER'S MA                                  | IDEN NAME                        |  |              |                |                      |
| ****   | 147   | V2 1 1   |                    | Geral  | dine Ree                         | ed   |              |                |                      |
| IS. WAS DECEASED EV  | liam Woodro   | ES? 16. SOCIAL SECURITY                              | Sm.<br>NO. [17. II | NFORMANT   |                                  | Add  | re49         |                |                      |
| [Yes, no, or unknown)  | (If yes, give war or dates of serv                              | Name   |                    | liam Wood  | row Brid                         |  |              | relvil         | lle, Me              |
| Conditions, if a gove rise to couse (a), stating lying couse lost.   | the under- CC               |  |                    |  |                                  |  |              | Tag            | 21                   |
| CAT  |   | ITIONS CONTRIBUTING TO I                             |                    |  |                                  |  | EN IN PART   | PER            | S AUTOPSY<br>FORMED? |
| □ OR CONTRIBUTING     □    □     □     □     □     □     □     □     □     □     □     □ | AS UNDERLYING [] 29<br>G [] CAUSE OF DEATH<br>MEDICAL EXAMINER) | 06. DESCRIBE HOW INJURY                              | OCCURRE            | D. (Enter noture of inju                         | ury in Part I or Par             | I If of ilem 18.)                          |              |                |                      |
| 20c. TIME OF INJUI<br>Hour o. m.<br>p. m.  | RY Month, Day, Year<br>19                                       | 20d, INJURY OCCURRED While Not while of work of work | 20e. PL/<br>fac    | ACE OF INJURY (Home<br>story, street, office bld | e, form, 20f. (City<br>g., etc.) | or town)                                   | (Ce          | ounty)         | (Stote)              |
| ACTUAL SIGNATURE   | John A. Top   | Sopper   | at death           | occurred at 2                                    | ADDRESS (S                       | n the causes of freet, city or lown, in ia | and on the   |                |                      |
| 220. BURIAL, CREMATIC<br>REMOVAL (Specify  | ON, 22b. DATE THEREOF   | 22c. NAME OF CE                                      | METERY O           | R CREMATORY                                      | 22d. LOCA                        | TION (City, town,                          | hol          | ,              | lote)                |
| 3. FUNERAL DIRECTOR  | ~   | ADDRESS  |                    |  | REC'D BY REGIST                  | RAR 246. REGI                              | STRAR'S SIGI |                |                      |
| John J. H  | laier, Cumbe  | erland, Mary   | Land               | DA*  | TE MAY 1 9                       | '58 ( )                                    | 186.0        | /              |                      |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page VS A15 (4) 15M 10/57

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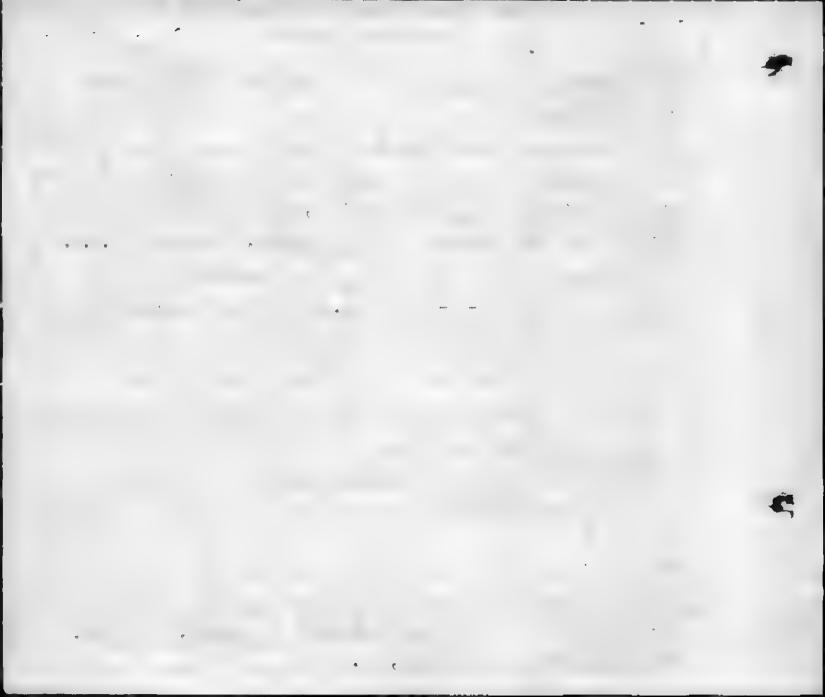
Longeoning, Md.

DATE MAY 2 9 53

George Eichhorn

VS A15 (4)

15M 9/55



VS A1S (4) 15M 10/57

H

#### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5181 **CERTIFICATE OF DEATH**

05177

Reg. Dist. No.

| 1 PLACE OF DEATH                          |  |                       |                  | 2. USUAL RESIDENCE (M            | Vhere deceased  |                     | on Residence  | before odm | (noizz      |
|---|--|-----------------------|------------------|----------------------------------|-----------------|---------------------|---------------|------------|-------------|
| ALLEGA                                    | NY   |                       | MARYLAND         | WEST V                           | IRGINIA         | b. COUNTY           |               |            |             |
| b. CITY OR TOWN (I<br>RURAL and give no   | If outside corporate limits,   | 1                     | H OF STAY IN 16  | c. CITY OR TOWN (IF              | outside corpor  | ote limits, write R | URAL and give | negrest to | vn)         |
| CUME                                      | ERLAND   | 28                    | DAYS             | KEYSER                           |                 |                     | ,             |            | ~           |
| d. NAME OF HOSPIT                         | MEMORIAL H   | Price ( add day)      |                  | d. STREET ADDRESS                |                 | *                   | *             | e IS R     | ESIDENCE    |
| MEMOR I                                   |  | K AVES.,              |                  | 9 SHARPLE                        | SS STRE         | ET                  | _             |            | A FARM?     |
| 3 NAME OF<br>DECEASED                     | First  |                       | Middle           | Lost                             | 4. DATE<br>OF   | Mon                 | th            | Day        | Yeor        |
| (Type or print)                           | MAT  |                       | М                | CAMPBELL                         | DEATH           | M.                  | AY            | 13         | 1958        |
| 5. SEX                                    | 6 COLOR OR RACE 7  | - MARRIED   NE        | VER MARRIED      | 8. DATE OF BIRTH                 |                 | 9. AGE (In years    | IF UNDER 1 Y  |            | DER 24 HRS  |
| FEMALE                                    | WHITE  | VIDOWED [             | DIVORCED 🗌       | NOV. 14 1 1                      | 1871            | 86 yrs              | Months Da     | ys Hour    | Min         |
| 10a. USJAL OCCUPATION during most of work | ON (Give kind of work doing life, even if retired) At Home   | ne 10b. KIND OF 8     | BUSINESS OR INDU | USTRY 11 BIRTHPLACE (SION CANADA | e or foreign co | unlry)              | U. S          |            | T COUNTRY   |
| 13. FATHER'S NAME                         |  |                       |                  | 14. MOTHER'S MAIDEN              | NAME            |                     |               |            |             |
| JO  | HN CAMPBELL  |                       |                  | JEAN MILL                        | ER              |                     |               |            |             |
| IS WAS DECEASED EVE                       | R IN U. S. ARMED FORCE   |                       | CURITY NO 17     | INFORMANT                        |                 | #9 Add              | Sharp         | less       | St.         |
| (Yas, no or unknown)                      | (ii yes, give war or bares or servi  | None                  | Mi               | ss <b>Jea</b> n Emi              | lly Fr          | ost,                | Keyse         | r, W       | .Va.        |
|   | ATH [Enter only one coust  | s per line for (o), ( | (b), and (c) ]   |                                  |                 |                     |               | INTERVAL I | BETWEEN     |
| PART I. DEA                               | TH WAS CAUSED BY: IMMEDIATE CAUSE (o)  | seal                  | Faile            | 21-                              |                 |                     |               | OINSLI AIN | DUCAIN      |
| 4261                                      | DUE TO   | - 1                   |                  | Λ                                |                 |                     | .2            |            |             |
| Conditions, if o                          | ny, which ) (b)_/  | Chines                | u M              | recediti                         | 2-12            | n' Inou             | Guar          |            |             |
| gove rise to i                            | mmediate ( Due to  |                       | , 1              | /                                |                 |                     | 00000         |            |             |
| lying couse lost.                         | (c)  | Den                   | ulut             |                                  |                 |                     |               |            |             |
| PART II. OTI                              | HER SIGNIFICANT CONDIT   | TIONS CONTRIBUT       | ING TO DEATH BU  | T NOT RELATED TO THE TERA        | MINAL DISEASE   | CONDITION GIV       | EN IN PART 1  | o) 19 WAS  | AUTOPSY     |
| CA1                                       |  |                       |                  |                                  |                 |                     | ì             | PERF       | ORMED?      |
| OR CONTRIBUTING                           | S UNDERLYING 20<br>CAUSE OF DEATH<br>MEDICAL EXAMINER)   | b. DESCRIBE HOW       | / INJURY OCCURRI | ED. (Enter nature of injury in   | Port I or Part  | II of item 16)      |               |            |             |
| \$ 20c. TIME OF INJUR                     | Y Month, Doy, Year   | 20d. INJURY OCC       |                  | ACE OF INJURY (Home, for         | m. 20f. (City   | or town)            | (Cou          | nly}       | (Stole)     |
| 20c. TIME OF INJUR                        | 19   | While Not v           | while            | ictory, street, office bldg., et | (c.)            |                     |               |            | . ,         |
| 21. I certify th                          | at I attended the d  | eceased fram          | 4-5-             | . 1958, to                       | 13              | 4, 1953             | that I lar    | t courth   | dacagene    |
| alive on 13                               | ma   |                       | and that death   | accurred of 145                  | A M from        | the source          | and on the    |            | and all and |
| 00 0                                      |  |                       | and attor deal   | 1                                |                 | eet, city or town.  |               |            | DATE SIGNED |
| ACTUAL                                    | 1000x 13   | holis                 | Morall           | 1-12                             | - 00            | 0,00                |               | , 2        | AAAC . C    |
| SIGNATURE                                 | THE PARTY OF THE P | f. senn               | 70.007           | MD. LALLACKY WI                  |                 |                     |               |            | 100         |
| PHYSICIAN'S<br>NAME (Type)                | FULLER B.  | WHITWORT              | Ή                |                                  |                 |                     | 4             |            |             |
| 270. BURIAL, CREMATIO                     |  | 22c NAA               | AE OF CEMETERY C | R CREMATORY                      | 22d LOCATI      | ION (City, lown, o  | or county)    | (Ste       | otel        |
| REMOVAL (Specify) Burial                  | Mare 16 19   | 58 Que                | econe 11         | musteren.                        | The             | usu/                | ,,            |            | 7/2         |
| 23. FUNERAL DIRECTOR                      |  | ADDI                  | RESS 1           | 24a. REC                         | 'D 8Y REGISTR   | AR 24b REGIS        | STRAR'S SIGNA |            | 100         |
| Theone                                    | or the   | eith                  | the Ken          | cun M. M. DATE                   | 11AV 1 5        | 158                 | (             | ula        |             |



Reg. Dist. No.

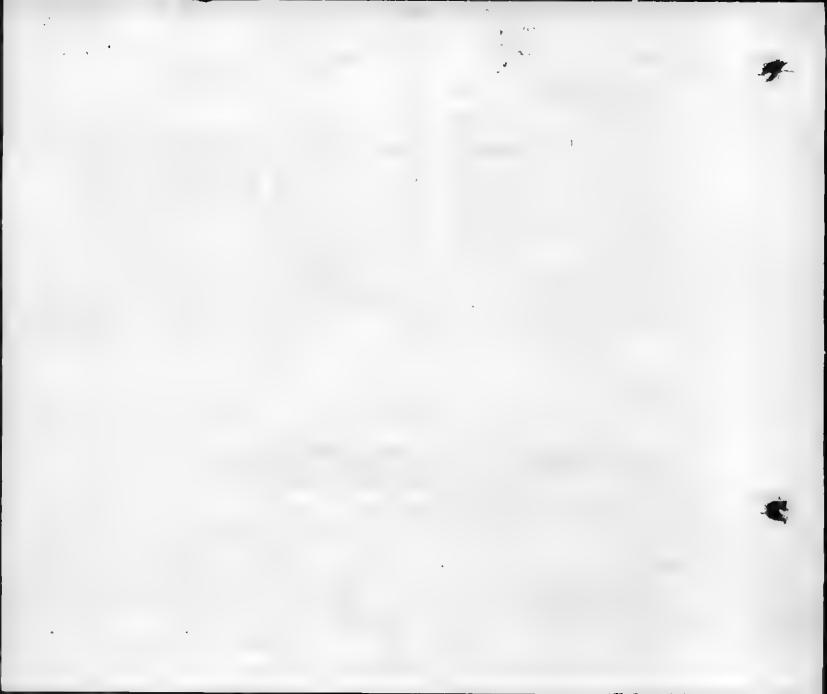
TO HOSPITAL OR ATTENDING PHYSICIAN: The faw requires that the death certificate be executed within 24 hours after death. Page

of ar attending physician. It is altered by the attending physician and campletely filled in by the funeral security to been signed by the attending physician and campletely filled in by the funeral security. Then please remove carbon papers. Pages I and 2 should be remained, or remayol, and in any event within 72 hours often death.

TO FUNERAL DIRECTOR: At page 3 should be detached the registrar prior to burial, city

VS A15 (4) 15M 10/57

|   |   |              |                            | · · · · · · · · · · · · · · · · · · · |                 |                |                              |              |                              |
|---|---|--------------|----------------------------|---------------------------------------|-----------------|----------------|------------------------------|--------------|------------------------------|
| 1. PLACE OF DEATH O COUNTY                  | llegany   |              | MARYLAND                   | o. STATE                              | NCE (Where      |                | d. If instituti<br>b. COUNTY | on-Residence | before admission)            |
| b. CITY OR TOWN (If                         | outside corporate limi                          | ts, write    | c. LENGTH OF STAY IN 16    |                                       |                 |                | ımits, write R               |              | ve nearest town)             |
| Frostbu                                     |   |              | 10 days                    | ਜਾ ਜਾ                                 | costbi          | יין פיל נו     |                              |              |                              |
| d. NAME OF HOSPITAL                         |   | ive street   |                            | d. STREET AD                          |                 | 41-6           | ·····                        | -            | e IS RESIDENCE<br>ON A FARM? |
|   | ner's Ho  | snit         | all                        | 90                                    | ) Walr          | nut S          | treet                        |              | YES NO K                     |
| 3. NAME OF<br>DECEASED                      | Fir   |              | Middle                     | Last                                  | 4.              | DATE           | Mon                          | th           | Day Year                     |
| (Type or print)                             | Jame  | 5            | C.                         | Carde                                 | er              | OF<br>DEATH    | Ma                           | У            | 27th, 19 58                  |
| 5. SEX                                      | 6. COLOR OR RACE                                | 7. MARR      | IED NEVER MARRIED          | B DATE OF BIRTH                       |                 | 9. A           | GE (In years<br>at buthday)  |              | YEAR IF UNDER 24 HRS.        |
| Male  | White   | WIDOWI       | ED 💆 DIVORCED 🗌            | Sept.23                               | rd,18           | 83   "         | 74 yrs.                      | Months D     | Poys Hours Min.              |
| 10a USUAL OCCUPATION during most of working | (Give kind of work                              | done 10b.    | KIND OF BUSINESS OR INDU   | STRY 11 BIRTHPLA                      | CE (State or fo | reign country  | r)                           | 12. CITIZ    | EN OF WHAT COUNTRY           |
| Ret Driver                                  | -Salesma  | n St         | a ndard Oil                | Co.Mary                               | rland           |                |                              |              | USA                          |
| 13. FATHER'S NAME                           |   |              |                            | 14 MOTHER'S A                         | ALIDEN NAM      | E              |                              | ·l           |                              |
| Harle                                       | y Carder  |              |                            | Lora                                  | tta B           | rant           |                              |              |                              |
| 15. WAS DECEASED EVER                       |   |              | SOCIAL SECURITY NO 17 1    | NFORMANT                              |                 |                | Add                          | ress         |                              |
| (Yes, no or unknown)   If                   | yes, give wer or dotes of s                     |              | 14-05-5983 Rt              | ussell (                              | arder           | Box            | 319.F                        | rosti        | hure Md.                     |
| IB. CAUSE OF DEAT                           | H [Enter only one co                            | use per lin  | ne far (a), (b), and (c) ] |                                       |                 | -7             |                              | - 0 0 0 1    | INTERVAL BETWEEN             |
|   |   |              | RECIRONA L.                | r Chill                               | 418.1           | 13/4           | dde                          |              | ONSET AND DEATH              |
| 181.0                                       | DUE TO  |              |                            |                                       |                 |                | 1                            |              | -/ 100                       |
| Conditions, if on                           |   |              | Posterno 5: 1              | 1 1                                   | de              | . d. f         | dag                          | 1350         | Zund                         |
| gove rise to im                             | mediate ( Due To                                |              |                            | -                                     |                 |                |                              |              |                              |
| lying couse lost.                           | e fuger.  | 1            | 1/2/2/6                    | 123011                                | 11/11           | 6              |                              |              | R JAI.                       |
| PART II. OTHE                               | R SIGNIFICANT CON                               | DITIONS      | ONTRIBUTING TO DEATH BUT   | NOT RELATED TO 1                      | HE TERMINAL     | DISEASE CO     | NDITION GIV                  | EN IN PART   | I(o) 19 WAS ALTOPSY          |
| 15  |   |              |                            |                                       |                 |                |                              |              | PERFORMED? YES NO            |
| PART II. OTHE                               | UNDERLYING [] ] CAUSE OF DEATH EDICAL EXAMINER) | 20b. DES     | CRIBE HOW INJURY OCCURRE   | D (Enter noture of                    | njury in Port   | or Part II of  | item 18.)                    |              |                              |
| ZOc. TIME OF INJURY Hour o. m, p. m.        | Month, Doy, Ye                                  |              | NJURY OCCURRED 20e PL      | ACE OF INJURY (H                      | me, form, 2     | Of (City or to | own)                         | (Co          | unty) (State)                |
| Hour o.m,                                   | 19  | While of wor |                            | ctory, street, office I               | oldg., elc.)    |                |                              |              |                              |
| 21. I certify tha                           | t I attended the                                | deceas       | ed from 20162              | 19,19,6                               | 10              | 12-12          | 2. 19.5                      | Ithat I la   | st saw the decease           |
| alive an                                    | 9127  | , 19         | 55, and that death         |                                       |                 | -              |                              |              | date stated above            |
|   | 1 /   |              |                            |                                       | ADD             | RESS (Street,  | city or lown,                | stote)       | DATE SIGNE                   |
| SIGNATURE                                   | 4. 1.0  | <u>( )</u>   | 11.2007                    | M.D.                                  | 31/             | <u> </u>       | RII                          | e)           | 5/28/5                       |
| PHYSICIAN'S<br>NAME (Type)                  | Jetin   |              | Le vous                    |                                       | 11103           | 100            | 1 1:00                       | 170          |                              |
| 220. BURIAL, CREMATION                      | -   |              | 22c. NAME OF CEMETERY O    |                                       | 22d             |                | (City, lown,                 | or county)   | (Stote)                      |
| Burial                                      | 5-30-5  | B            | Oldtown Ce                 | emetery                               |                 | Oldto          | own,                         |              | Md.                          |
| 23. FUNERAL DIRECTOR'S                      |   | -            | ADDRESS                    |                                       | 40. REC'D BY    | REGISTRAR      | 24b. REGI                    | STRAR'S SIGN | NATURE                       |
| I Joseph R                                  | . Durst.  | F'r          | ostburg, Md                | •                                     | DATE STEEL O    | 159            | 1000                         |              | 1                            |



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05179

| 182 | CERTIFICATE | OF DEATH |
|-----|-------------|----------|
|-----|-------------|----------|

Ren Dist No.

|   |                                      | 4-4-4-6-      |                     |             |   |                |                         | well nist      |                      |
|---|--------------------------------------|---------------|---------------------|-------------|---|----------------|-------------------------|----------------|----------------------|
| 1. PLACE OF DEATH<br>o. COUNTY                            |                                      |               |                     |             | USUAL RESIDENCE                               | (Where dece    | ased lived If instituti | on: Residence  | before admission)    |
| ΔΤ.1  | THANY                                |               | MARYL               | AND         | MAR   | YT.AND         | b. COUNT                | ALLEGA         | A TATE               |
| b CITY OR TOWN (  | outside corporate limits,            | write c LE    | NGTH OF STAY II     | N 1b        |   |                | rporate limits, write R | III Al ond on  | Ne secret lows)      |
| RURAL ond give ne   |                                      |               |                     |             |   | (0.0.00 00     | porote thom, write it   | OWNE ONE ON    | ve nediesi ionii     |
| CUMBE   | ERI,AND                              |               |                     | 1.5         | ∠≪ CUMBERI                                    | LAND           |                         |                |                      |
| d. NAME OF HOSPITA  | AL (If not in hospital, give         | street addres | 5]                  |             | d. STREET ADDRESS                             |                |                         |                | e. IS RESIDENCE      |
| OR INSTITUTION SACREI                                     | TIPADO MOGD                          | TMAT          |                     | - 1         | /   |                |                         |                | ON A FARM?           |
| DAUREL  | HEART HOSP                           | LTAL          |                     |             | 306_T   | JAVERE         | LY TERRACE              | c              | YES NO Z             |
| 3. NAME OF  | First                                |               | Middle              |             | Lost  | 4. DAT         | E Mor                   | ith            | Day Year             |
| (Type or print)   | MA                                   | DA            | AT TITE             |             | O A TO TOWN TO                                | OF<br>DEA      |                         |                |                      |
|   |                                      |               | OLIVIA              |             | CARPENTI                                      | DEA            | MAY                     |                | 4 1958               |
| 5. SEX  | 6. COLOR OR RACE 7.                  | MARRIED _     | NEVER MARRIED       | ) 🔲   B.    | DATE OF BIRTH                                 |                | 9. AGE (In years        | }              | YEAR IF UNDER 24 HRS |
| FEMALE  | WHITE W                              | /IDOWED 🖂     | DIVORCED            |             | NE 2. 1887                                    | ,              | lost birthdoy)          | Months D       | Pays Hours Min       |
| 10n USUAL OCCUPATIO                                       | N (Give kind of work dor             | -             | OS BUSINESS OR      | INDUST.     | TIP PURTURE ACT (C)                           |                |                         | 120 0          |                      |
| during most of work                                       | ing life, even if retired)           | TOD KIND      | OL BOSHAESS OK      | IIADO211    | III. BIRTHFUACE (SI                           | ore or roreigi | COUNTRY                 | 12. CITIZ      | EN OF WHAT COUNTRY   |
| Но  | usewife                              | Ov            | vn Home             |             | Fano Ad                                       | riano          | . Italy                 | TT             | SA                   |
| 13. FATHER'S NAME   |                                      |               | 110110              |             | 14 MOTHER'S MAIDE                             |                | 3 I OUIL                |                | DA                   |
| *00-  | trans and the same                   |               |                     |             |   | 11111111       |                         |                |                      |
| JOSE  | PH AMADIO                            |               |                     |             | Olivi   | a VeC          | ii a                    |                |                      |
|   | IN U 5 ARMED FORCE                   |               | L SECURITY NO       | 17. INF     | DRMANT  |                | Add                     | ress           |                      |
|   | If yes, give war or dates of service |               |                     | Ton         |   |                |                         |                |                      |
| no  |                                      |               | one                 | L PI        | S. CHART.                                     |                |                         |                |                      |
| 18. CAUSE OF DEA  | TH [Enter only one couse             | per line for  | (o), (b), and (c) ] |             |   |                |                         |                | INTERVAL BETWEEN     |
| PART I. DEAT  | TH WAS CAUSED BY:                    | 14            | a ada.              |             | andio.  | 1/             |                         | <u> </u>       | ONSET AND DEATH      |
|   | IMMEDIATE CAUSE (o)                  | 7-5           | ryvino              | we          | a-waren                                       | - Vas          | entre                   | Dise           | al                   |
| 4401  | DUE TO                               | U             | •                   |             |   |                |                         |                |                      |
| Conditions, if on   | v. which )                           |               |                     |             |   |                |                         |                |                      |
| gove rise to in   | madiole (                            |               |                     |             |   |                |                         |                |                      |
| couse (o), stoling t                                      |                                      |               |                     |             |   |                |                         |                |                      |
| lying couse lost.   | ) (c)_                               |               |                     |             |   |                |                         |                |                      |
| PART II. OTH  | ER SIGNIFICANT CONDIT                | IONS CONTR    | BUTING TO DEAT      | H BUT NO    | OT RELATED TO THE TE                          | PAINAI DISE    | ASE CONDITION CIV       | ENI INI DAGE I | I ID WAS ALITODRY    |
| PART II. OTH  | 2 1                                  | 1 - 10        | .00.1               |             | Prince to the le                              | TOTAL DISE     | ASE CONDINON ON         | CH III FARL    | PERFORMED?           |
| 5 21 17   | 15 cares                             | JA.           | excor               |             |   |                |                         |                | YES NO               |
| 200 ACCIDENT WAS<br>OR CONTRIBUTING<br>(IF EITHER, NOTIFY | UNDERLYING   20                      | b. DESCRIBE I | HOW INJURY OC       | CURRED      | Enter nature of injury                        | in Port I or F | ort II of item 18 )     |                |                      |
| UF EITHER, NOTIFY   | CAUSE OF DEATH                       |               |                     |             |   |                |                         |                |                      |
|   |                                      |               |                     |             |   |                |                         |                |                      |
| Hour o. m.  | Month, Doy, Year                     | 20d. INJURY   |                     | Ge. PLACI   | OF INJURY (Home, for y, street, office bldg., | orm, 20f (C    | ily or lown)            | (Co            | unty] (Stole)        |
| 20c. TIME OF INJURY<br>Hour o. m.                         | 19                                   | While ↑       | Not while           | , IUCIOI    | y, wreel, office blog.,                       | eic )          |                         |                |                      |
| < p. m.   |                                      |               |                     | _           | - 11  | 11             |                         | ~              |                      |
| 21. I certify the   | at Jattended the de                  | eceased fro   | om                  | 7           | 19 V 8, to_                                   | 3/4            | . 19 50                 | that I la      | st saw the deceased  |
| alive on  | V/ 44                                | 1058          | and that d          | المسالة الم | .9.2  | 2/2            |                         |                |                      |
| and on  | 7                                    |               | _, ond mar a        | ream a      | ccouled of Arma                               |                |                         |                | date stated obove    |
|   | 2                                    | 4             | 0.0                 |             |   | ADDRESS        | (Street, city or town,  | stole)         | DATE SIGNED          |
| SIGNATURE   | 10 N.                                | Xen           | 34.                 | 84.1        | He 6 1  | 1/ Ce          | when it                 | - Com          | 1/1/18               |
|   | ব                                    | 1             | 1                   |             | ·   | W. A           |                         |                |                      |
| PHYSICIAN'S   | IEN W                                | 1 = V         | 10                  |             | 0.  | 1.0            | 0 5                     | 0              | /                    |
| NAME (Type)   | LOU /1. 1                            |               | V .                 |             | Cum   | E-6-1          | un In                   | a.             |                      |
| 220 BURIAL CREMATION                                      | 1, 22b. DATE THEREOF                 | 22c.          | NAME OF CEMET       | ERY OR C    | REMATORY                                      | 224 100        | ATION (City, Iown, o    | ar county)     | /Shm t- \            |
| REMOVAL (Specify)   | 35                                   |               |                     |             |   |                |                         |                | (Stote)              |
| Burial  |                                      |               | it. Pat:            | rick        | 1s Cemet                                      | erv            | Cumberla                | nd $M$         | d                    |
| 23. FUNERAL DIRECTOR'S                                    | SIGNATURE                            |               | DDRESS              |             |   |                | STRAR 246 REGIS         |                | IATURE               |
| James F.  | Scarpell                             | i. Cur        | nberlan             | d. N        | d - DATE                                      | MAY            | 8 '58                   | Brown Rot      | h h * .h             |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours ofter death. Page may be retained by the hostatol or attending physician.

TO FUNERAL DIRECTOR: A his certificate has been signed by the attending physician and campletely filled in by the funeral of page 3 should be detached for use as the burial-transit permit. Then please remave carban pages. Pages 1 and 2 should be the registrar prior to burial, are movial, and in any event within 72 hours after death VS A15 (4) 15M 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 13



|  | _  | _                                     |                                    |                      | _        |
|--|--|---------------------------------------|------------------------------------|----------------------|----------|
|  |  |                                       |                                    | 1                    | -        |
|  | F  | 0                                     | R                                  | Si                   | AT<br>DE |
| h  | Ht.                                      | ٥                                     | Ш                                  | ታ                    | DE       |
| pleasa   | Pogg                                     | iles                                  | 000                                |                      | W        |
| 4 hours after death. If any delay is necessary, please | , 2, and 3 to the funeral director. Page | Page 5 may be retained far your files | and 2 with the State Board of Hea. |                      | _        |
| / IS nec   | eral di                                  | ned fa                                | te Baa                             | 4                    |          |
| y dela   | he fun                                   | e refai                               | he Sta                             | er dea               |          |
| TO T   | 3 10 2                                   | may b                                 | with t                             | '2 hours after death |          |
| death.   | 2, and                                   | oge 5                                 | and 2                              | ₹2 ho                |          |
| affer .  | Jes 1,                                   | -                                     | 7 305                              | Within               | I        |
| thous  | ive Pages 1                              | orm PM3.                              | ile po                             | event                | -        |
|  |  |                                       |                                    |                      |          |

PLACE OF DEATH

ALLEGANY

b. CITY OR TOWN (If outs de corporate limits, write RURAL

CUMBERLAND

John J. Hafer, 2 0 Baltimore Ave.

o COUNTY

### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05181 Reg. Dist. Na. 2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) MARYLAND P CORNIA ALLEGANY MARYLAND c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporale limits, write RURAL and give negres) town) X RURAL CUMBERLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? YES NO DA ROUTE 4. CUMBERLAND, MD 4. DATE Manth Year DEATH MAY 1958 9 AGE Illn years feet birthday] Months Days Hours Min 59 yrs APRIL 7. 1899 Keedvsville, Md.

DEAD ON ARRIVAL-SACRED HEART HOSPIT 3. NAME OF Middle DECEASED SAMUEL MARTIN CLOPPER. (Type or print) 6. COLOR OR RACE 7. MARRIED NI NEVER MARRIED 1 8 DATE OF BIRTH FUNDER TYEAR IF UNDER 24 HRS MALE WHITE WIDOWED [7] DIVORCED T 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (Slote or foreign country) during most of working life, even if refired) 12 CITIZEN OF WHAT COUNTRY? Auto & Diesel Mechanic Construction U. S. A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME FRISBY MARTIN CLOPPER VIRGINIA FRANCES PHFFENBURGER 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address Was no ne unhaqual Ill yes, give wer or deter of servicel 214-05-5378 Mrs. Samuel M. Clopper. Sr. Rt. 4, Cumberland INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH [finter only one cause per line for (o), (b), and (c) PART I. DEATH WAS CAUSED BY: Cerebral Hemorrhage 2hrs. IMMEDIATE CAUSE (a) DUF TO Hypertensive Cardiovascular Disease Conditions, if any, which) gave rise to immediate cause DUE TO (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPS PERFORMED? NO G 20g. EXTERNAL CAUSE WAS PRIMARY OF OCCURRENTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED, (Enter noture of injury to Port I or Port II of item 18.1 Month, Doy, Year 20d, INJURY OCCURRED [20e. PLACE OF INJURY (Home, form, 120f. (City or lown) 20c. TIME OF INJURY (County) (Stote) factory, street, office bldg., etc.) While Not while a m of work of work DO p. m. 21. I certify that I taak charge of the remains described above, held an Autapsy [], Inspection [], Inquiry [] and in my opinian death resulted from. Natural couses X. Accident ... Suicide , Homicide , Undetermined manner ACTUAL DATE SIGNED CHIEF MEDICAL EXAMINER SIGNATURE Skitarelic, M.D. Be nedict ASSISTANT MEDICAL EXAMINER May 27, 1958 NAME (Type) Congania Skitarelic DEPUTY MEDICAL EXAMINER TX 220. BURIAL CREMATION 226 DATE THEREOF 22d LOCATION (City, town, or county) 22c NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) 5/31/58 Burial Sunset Memorial Park Cumberland, Maryland 23 FLINERAL DIRECTOR'S SIGNATURE **ADDRESS** 240 REC'D BY REGISTRAR 246 REGISTRARYS SIGNATURE

DATE

VS A15ME

5M 2 57



05182

CERTIFICATE OF DEATH

| PLACE OF DEATH COUNTY ATJEGANY   |  |  |  |  |   |   |                                  |
|--|--|--|--|--|---|---|----------------------------------|
|  |  | MARYLAND   | g. STATE  MARYT.A  |  | b. COUNTY   | on Residence be                           | fore admission                   |
| b. CITY OR TOWN (I   | outside corporate limits, write  | c. LENGTH OF STAY IN 16  |  |  |   | Market Art All Day                        | neorest town)                    |
| CUMBERLAN  | D D  | 51 DAYS  | X RURAT.   |  | ECKHAR  | offin                                     |                                  |
| d. NAME OF HOSPITA<br>OR INSTITUTION<br>SACRED   | At (If not in hospital, give street HEART HOSPITAL   | address)   | / d. STREET ADDRESS  |  | PARATIAN  | -   | e. IS RESIDE<br>ON A FA          |
| NAME OF<br>DECEASED<br>(Type or print)   | First<br>GRIFFITH  | Middle<br>T D'OTHY   | CONNER   | 4. DATE<br>OF<br>DEATH                                   | Mon!<br>MAY                                       | th 18                                     | Day Yea                          |
| S. SEX MATE  | 6. COLOR OR RACE 7 MARR  | HED NEVER MARRIED DIVORCED   | B DATE OF BIRTH 9/2/02   | 9  | AGE (In years last birthday)                      | Months Days                               |                                  |
| 00 USUAL OCCUPATIO   | N (Give kind of work done 10b. ing life, even if retired)  |  | SUSTRY 11 BIRTHPLACE (State  | or foreign cou   |   |   | OF WHAT CO                       |
| 3. FATHER'S NAME   | 1177347  | MENTAL OF FLINGE   | 14. MOTHER'S MAIDEN N  |  |   | Ui  | SA                               |
|  | CONNER (DECE   | ASRD)  | ENMA DAVI  | ,  | CEASED)   |   |                                  |
|  | (  | ,  | INFORMANT  | S (1317)   | Addr  |   |                                  |
|  | If yes, give wor or doles of service)  | 16-10-6822   | PATIENTS CHAR  | T  | Addr  | ress                                      |                                  |
| PART I. DEAT  456×  Conditions, if on  | TM (Enter only one cause per lin IM WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Ty, which   | to Engl  | of Present   | Die  | in  |   | SET AND DE                       |
| PART I. DEAT  L456 X  Conditions, if on gove rise to in couse (o), stoling t lying couse lost.   | TM (Enter only one cause per ling the WAS CAUSED BY IMMEDIATE CAUSE (a)  DUE TO  Ty, which (b)   | ful Engl   | T Present to the TERMI   | Disease (  | CONDITION GIVI                                    | 01  | 2,41                             |
| PART I. DEAT  456  Conditions, if on gove rise to im couse (o), stoling to laying couse lost.  Part II OTH  470  200. ACCIDENT WALLOW OR CONTRIBUTIONS   | TM (Enter only one cause per line IM WAS CAUSED BY IMMEDIATE CAUSE (o)  DUE TO  Ty, which a mediate the under.  ER SIGNIFICANT CONDITIONS CONDI | LOS ENTE   | UT NOT RELATED TO THE TERMI  |  |   | 01  | Z. y 1                           |
| PART I. DEAT  L456 X  Conditions, if on gove rise to in couse (o), stoling t lying couse lost.   | TM (Enter only one cause per line in WAS CAUSED BY IMMEDIATE CAUSE (a)  DUE TO  DUE TO  Ly, which the under (c)  ER SIGNIFICANT CONDITIONS CO  S UNDERLYING (C)  C C C C C C C C C C C C C C C C C C   | CRIBE HOW INJURY OCCURION OCCURRED 200.  |  | Port I or Port I   | I of item 18.)                                    | 01  | 2. 11  19 WAS AUI PERFORM YES  N |
| PART I. DEAT  456 X  Conditions, if on gove rise to in gove ri | TM (Enter only one cause per line in WAS CAUSED BY IMMEDIATE CAUSE (a)  DUE TO  DUE TO  Ly, which the under (c)  ER SIGNIFICANT CONDITIONS CO  S UNDERLYING (C)  C C C C C C C C C C C C C C C C C C   | CRIBE HOW INJURY OCCURION Not white of work of | PLACE OF INJURY (Home, farm factory, street, office bldg., etc.                                  | 20f. (City o   | the causes a                                      | (County)                                  | 19 WAS AUT PERFORM YES N         |
| PART I. DEAT  1456  Conditions, if on gove rise to in couse (o), stoling the lying couse lost.  PART II OTH  490 A  200. ACCIDENT WAS OR CONTRIBUTING (IF EITHER, NOTIFY to m.m., p.m.  21. I certify the clive on ACTUAL SIGNATURE  | TM (Enter only one cause per limit WAS CAUSED BY IMMEDIATE CAUSE (a)  DUE TO  Ty, which the under (c)  ER SIGNIFICANT CONDITIONS CO  S UNDERLYING (c)  S UNDERLYING (c)  A CAUSE OF DEATH MEDICAL EXAMINER)  (Month, Day, Year 20d. If White of world at the decease 19.   | CRIBE HOW INJURY OCCURING Not white of work control of the control | PLACE OF INJURY (Home, farm factory, street, office bldg., etc.                                  | 20f. (City o   | or town)  | (County)                                  | IP WAS AUT PERFORM YES N         |
| PART I. DEAT  LY 5 6 X  Conditions, if on gove rise to im gove rise to import to the condition of  | TM (Enter only one cause per limits was CAUSED BY IMMEDIATE CAUSE (a)  DUE TO  TO TO TO TO TO TO TO TO TO TO TO TO TO T  | CRIBE HOW INJURY OCCURING Not white of work control of the control | PLACE OF INJURY (Home, farm factory, street, office bldg., etc, 19,56 to 10 th occurred at 12:35 | 20f. (City of )  | the causes a                                      | (County  Athat ) last and an the district | 19 WAS AUT PERFORM YES N         |
| PART I. DEAT  L456 X  Conditions, if on gove rise to im couse (o), stoling to lying couse lost.  PART IF OTH  L490 X  20c. ACCIDENT WAND ON CONTRIBUTING (IF EITHER, NOTIFY IF Hour o.m., p. m.  21. I certify the clive on ACTUAL SIGNATURE  PHYSICIAN'S  | TM (Enter only one cause per limits was CAUSED BY IMMEDIATE CAUSE (a)  DUE TO  TO TO TO TO TO TO TO TO TO TO TO TO TO T  | CRIBE HOW INJURY OCCURING Not white of work control of the control | PLACE OF INJURY (Home, farm factory, street, office bldg., etc., 1956 to 10 th occurred at 12:35 | 20f. (City of )  Author  ADDRESS ISITE  St. (22d LOCATIO | x lown)  x lown)  the causes a set, city or town, | (County)  that I last and an the district | 19 WAS AUT PERFORM YES N         |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained by the hospital ar attending physician.

TO FUNERAL DIRECTOR: After a securificate has been signed by the attending physician and completely filled in by the funeral during page 3 should be detached in use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 should be filly with the registrar prior to burial, cremation, or remaval, and in any event within 72 haurs after death. VS A15 (4) 15M 10/57



VS A15 (4) 15M 10/57

M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

**CERTIFICATE OF DEATH** 

05183 Reg. Dist. No.

51.86

|          | 1. PLACE OF DEATH                           | -01-0   |                           | 2 USUAL RESIDENCE (W                                     |                           |                     | e before admissio            | n)          |
|----------|---|---|---------------------------|--|---------------------------|---------------------|------------------------------|-------------|
|          | ALLE  | GANY  | MARYLAND                  | o. STATE MARYLA  | AND b. (                  | COUNTY ALLE         | GANY                         |             |
| )        | RURAL and give nea                          | outside corporole limits, write                         | C. LENGTH OF STAY IN 16   |  | outside corporale limit   | , write RURAL and g | ive nearest fown)            |             |
|          | CUMBERL                                     |   | 19 DAYS                   | d. STREET ADDRESS  | KLAND                     |                     | 1 as been                    | P. L. order |
| ı.       | OR INSTITUTION WARWICK A                    | MEMORIAL HOSP<br>ND MEMORIAL AVI                        | ĨŢĂĹ                      |  | EDFORD STRE               | ET                  | e, IS RESID<br>ON A F<br>YES | ARM?        |
|          | 3 NAME OF                                   | First   | Middle                    |  | 4. DATE                   |                     |                              |             |
|          | DECEASED<br>(Type or print)                 | NETTIE  | LEE                       | COOPER   | OF<br>DEATH               | MAY                 | 24 10                        | 58          |
|          | 5. \$EX                                     | 6. COLOR OR RACE 7 MARR                                 | IED NEVER MARRIED         | 8. DATE OF BIRTH   | 9. AGE (                  | In years IF UNDER   | YEAR IF UNDER                |             |
|          | FEMALE                                      | WHITE WIDOWS  | DIVORCED                  | MAY 11, 18   | 30 6                      | Manths Months       | Days Haurs                   | Min         |
|          | 10a. USUAL OCCUPATION during most of worki  | N (Give kind of work done 10bing life, even if retired) | KIND OF BUSINESS OR INDE  | ISTRY 11. BIRTHPLACE (Stoke                              | or foreign country)       | 12. CITI            | ZEN OF WHAT C                | OUNTRY      |
|          | Clerk                                       |   | lothing sto               | re WEST VIE  | RGINIA                    | U.                  | S. A.                        |             |
|          | 13. FATHER'S NAME                           |   |                           | 14. MOTHER'S MAIDEN                                      | NAME                      |                     |                              |             |
| The same |   | WESTFALL  |                           | CARRIE BEL   | L RYMER                   |                     |                              |             |
| 1        |   | IN U. S. ARMED FORCES? 16.                              | SOCIAL SECURITY NO. 17.   | INFORMANT  |                           | Address             |                              |             |
|          | No  | 2   | 216-22-5849               | MEMORIAL HOS   | SPITAL -                  | CUMBERLAN           | D, MD.                       |             |
|          |   | TH [Enter only one couse per lin                        | e for (o), (b), and (c).] | 1 (  | 4                         | ,                   | INTERVAL BETY                |             |
|          | PART 1. DEAT                                | H WAS CAUSED BY: IMMEDIATE CAUSE (0)                    | archemi                   | 11 tosi's /C   | nerali                    | 2 = 4               | ONSET AND D                  | LAIR        |
|          | 153.3                                       | B DUE TO  | •                         | ~  |                           |                     |                              |             |
|          | Conditions, if on                           | y, which ) (b) (d)                                      | denv- Co                  | er como  | Diame                     | الت                 |                              |             |
|          | gove rise to im<br>cause (a), stating th    |   |                           |  |                           |                     |                              |             |
|          | lying couse lost.                           | ) (c)   |                           |  |                           |                     |                              |             |
|          | PART II. OTHE                               | ER SIGNIFICANT CONDITIONS C                             | ONTRIBUTING TO DEATH BU   | T NOT RELATED TO THE TERM                                | NINAL DISEASE CONDIT      | ION GIVEN IN PART   | 1(0) 19. WAS AU              | TOPSY       |
| )        | PART II. OTHE                               |   |                           |  |                           |                     | AE2                          |             |
|          | 20g ACCIDENT WAS<br>OR CONTRIBUTING I       | UNDERLYING 206. DESC                                    | RIBE HOW INJURY OCCURRI   | D. (Enter noture of injury in                            | Port 1 or Port 11 of item | a 18.)              |                              |             |
|          |   | AEDICAL EXAMINER)                                       |                           |  |                           |                     |                              |             |
|          | 20c. TIME OF INJURY<br>Hour o. m.           |   | S                         | ACE OF INJURY (Home, forestory, street, office bldg., et |                           | {C                  | punty)                       | (Stole)     |
|          | p. m.                                       | 19 While of work  | - ADI MIING               | cory, sieer, office blog., ex                            | 6]                        |                     |                              |             |
|          | 21. I certify the                           | at I attended the decease                               | ed from Som               | 1958, to 2   | ymn                       | 1958, that I le     | ast saw the d                | ocogsoci    |
|          | alive an                                    | J Men 195   |                           | accurred at 4:15F  |                           |                     |                              |             |
|          | 7   |   |                           | 1  | ADDRESS (Street, city     |                     |                              | E SIGNED    |
|          | SIGNATURE TO                                | eller 13 h  | luluot                    | MO. Cimb   | uline V                   | nd                  | 26 M                         | 058         |
|          | PHYSICIAN'S                                 |   |                           |  |                           |                     |                              | 7-3-5       |
|          | NAME (Type) D                               | R. FULLER B. WI   | II TWORTH                 |  |                           |                     |                              |             |
|          | 22a. BURIAL, CREMATION<br>REMOVAL (Specify) | , 226. DATE THEREOF                                     | 22c NAME OF CEMETERY C    | OR CREMATORY   | 22d. LOCATION (City       | , town, or county)  | (Store)                      |             |
|          | Burial                                      | 5/27/58   | Hillcrest                 | Burial Par   | k Cumber                  | land A              | larvlan                      | d           |
|          | 23. FUNERAL DIRECTOR'S                      |   | ADDRESS                   | 24a. REC   |                           | E REGISTRAR'S SIG   |                              |             |
|          | Ruth E.                                     | Silcox Cum  | berland, Mai              | rvland DATEMA  | Y 2 8 '58                 | Mitesu              | ch                           |             |

Cumberland, Maryland



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5187 CERTIFICATE OF DEATH

05184

Rea. Dist. No. . PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived II institution. Residence before admission) COUNTY o STATE Allegany **b.** COUNTY MARYLAND Hary Land Allegany b. CITY OR TOWN IIf outside corporate limits, write c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) c. LENGTH OF STAY IN Th RURAL and give nearest town) Cumber 1 and Cumber Land. d. NAME OF HOSPITAL (If not in haspital, give street address) d STREET ADDRESS e. IS RESIDENCE 312 Independence St. ON A FARM? 312 Independence St. YES NO 3. NAME OF First Middle 4. DATE Month Day Yeor DECEASED OF DEATH James Albert C1vde Crosby (Type or print) Hay 21 1058 S. SEX 6 COLOR OR RACE 7. MARRIED TO NEVER MARRIED 8 DATE OF SIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Dovs Hours White June 21. 1894 Male WIDOWED [7] DIVORCED [7] 10a. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (Stole or foreign country) 12 CITIZEN OF WHAT COUNTRY during most of working life, even if retired) Bedford Co. Penna. U. S. A. Carman helper B. & O. Riv. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Josiah Crosby Elizabeth Brennan IS WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT Address Cumberland, Md. No. 705-09-3447 Irs. Sylvia L. Crosby 312 Independence St 18. CAUSE OF DEATH | Enter only one couse per line for (o), (b), and (c). INTERVAL SETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: CEREBRAL HEMORRHAGE HR DUE TO Conditions, if any, which HYPERTENSION gove rise to immediate DUE TO couse (o), stoting the underlying couse lost. CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED? YES NO 200 ACCIDENT WAS UNDERLYING TO OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port II of item 18.) 20c. TIME OF INJURY Month, 20e. PLACE OF INJURY (Home, form, 20f. (City or town) Day, Year 20d INJURY OCCURRED (County) (State) factory, street, office bldg., etc.) O. m. While Not while of work of work 21. I certify that I attended the deceased from JUNE \_\_\_\_, 1956\_, 10\_ MRY ....... 1958 that Flast sow the deceased \_, and that deoth occurred ot 7:00 AM, from the couses and on the date stated above ADDRESS (Street, city or town, stote) DATE SIGNED ACTUAL CENTRE ST SIGNATURE PHYSICIAN'S NAME (Type) WILLIAM P LAMES . M.D CHMBERLAND. MD. 220 BURIAL, CREMATION, 226, DATE THEREOF 22c NAME OF CEMETERY OR CREMATORY 22d LOCATION (City, lown, or county) (Stote) REMOVAL (Specify) Hyndman Cem. 24/58 Jurial Hyndman. Penna. 23. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 24b REGISTRAR'S/SIGNATURE 24a. REC'D BY REGISTRAR Charles L. George MAY 2 6 '58 Cumberland, Maryland DATE

death. pe should .5 filled campletely popers. ofter death and carban mave be burial-transit puo Use DIRECTOR shauld be O FUNERAL F 2 VS A15 (4) 1SM 10/57

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PART IF OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(4) 19. WAS AUTOPSY

PERFORMED? YES NO TO

(IF EITHER, NOTIFY MEDICAL EXAMINER)-20c. TIME OF INJURY Day, Year Hour o. m.

20a ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH

20d INJURY OCCURRED of work at work

1, and that death occurred at 7:15

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18/

20e. PLACE OF INJURY (Home, form, 20f., (City or lown) factory, street, office blog., etc.) !

(County) (Stote)

21 I certify that I attended the deceased from 1/1 2 S

7 . 19 53, that I last saw the deceased

ADDRESS (Street, city or town, stote)

Cumberland, Maryland

ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)

Burial

220 BURIAL CREMATION, 22b. DATE THEREOF REMOVAL (Specify)

22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park

22d LOCATION (City town, or county)

(Stote)

23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George Cumberland, Ild.

**ADDRESS** 

24a REC'D BY REGISTRAR DATE MAY 1 2 '58

24b. REGISTRAR'S SIGNATURE

0 VS A15 (4)3 1 15 16 15M 10/57

FUNER

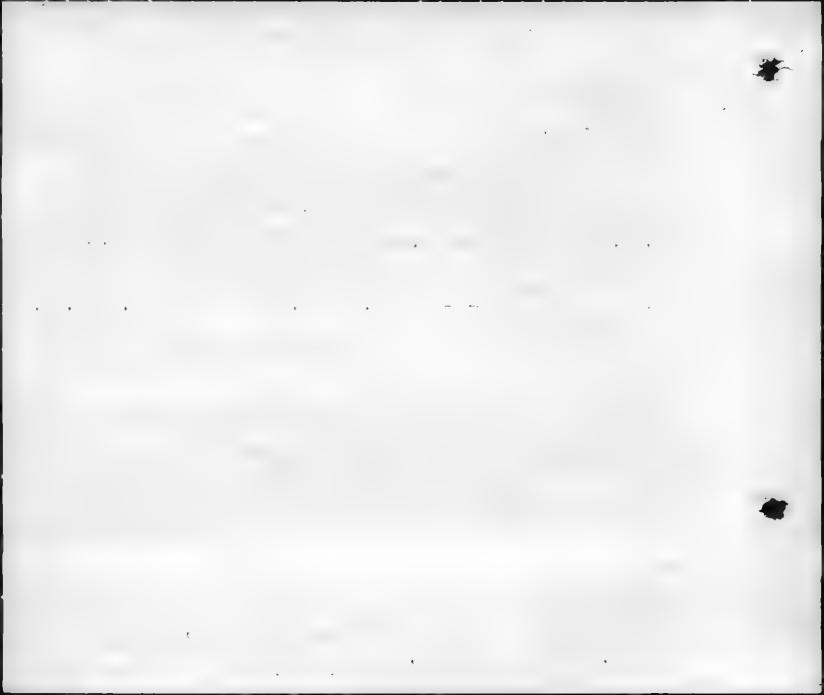
death

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VS A15 (4) 15M 10/57 6 2

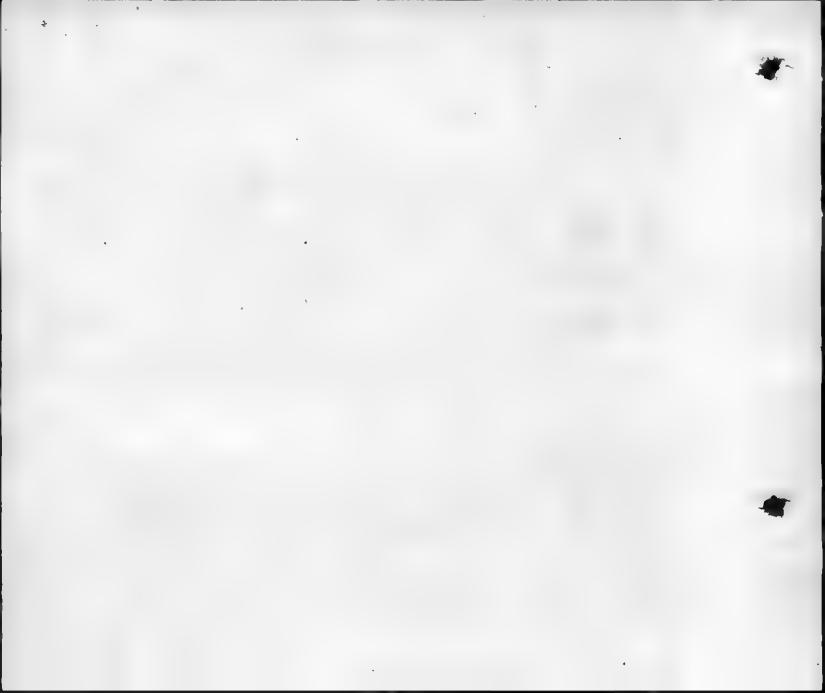
0

05186

Reg. Dist. No.

5189 CERTIFICATE OF DEATH

| _   |  |  | Street, Square, |                         |                         |   |                                    |                     |                     |            |  |
|---|--|--|-----------------|-------------------------|-------------------------|---|------------------------------------|---------------------|---------------------|------------|--|
| 1. PLACE OF DEATH a. COUNTY   |  |  |                 |                         | . II o STATE            | 2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE b. COUNTY |                                    |                     |                     |            |  |
| _   |  | gany   |                 | MARYLANE                | 1.1                     | Maryland Allegany   |                                    |                     |                     |            |  |
| b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) |  |  |                 |                         | c. CITY OR              | c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town)                      |                                    |                     |                     |            |  |
| Cumberland 5 days   |  |  |                 |                         |                         | Cumberland  |                                    |                     |                     |            |  |
| d. NAME OF HOSPITAL (If not in haspital, give street address) OR INSTITUTION    |  |  |                 |                         | 11 5                    | d STREET ADDRESS  e. IS RESIDENCE ON A FARM3  |                                    |                     |                     |            |  |
| S   | acred Hear   | t Hospital   |                 |                         | 510 Ba                  | ltimore   |                                    |                     | YES                 | □ NO 💁     |  |
| 3. NAME OF<br>DECEASED<br>(Type or print)                                       |  | Alice  |                 | Middle                  | Los                     | 4. DAT  | E Moi                              | Month Doy<br>May 14 |                     | Year       |  |
|   |  |  |                 |                         | Dene                    |   | тн Ма                              |                     |                     | 14 1958    |  |
| 5 SEX<br>Female   |  | 6. COLOR OR RACE 7 MARR  |                 | IED NEVER MARRIED       | 8. DATE OF BIRT         | н   | 9. AGE (In years<br>lost birthday) |                     | YEAR IF UN          |            |  |
|   |  | White  | WIDOWI          | DIVORCED                | 6/3/96                  |   | 61 yrs.                            |                     | Days Hou            | rs Min     |  |
| 100   | . USUAL OCCUPATIO  | IN (G've kind of work a  | done 10b.       | KIND OF BUSINESS OR INC | DUSTRY 11 BIRTHPI       | IACE (Stole or foreign  | n country)                         | 12 CITI             | ZEN OF WH           | AT COUNTRY |  |
|   | House ke   |  | '               | At home                 | Pen                     | Penn. U.S.A.  |                                    |                     |                     |            |  |
| 13.   | FATHER'S NAME  |  |                 |                         | 14 MOTHER'S             | MAIDEN NAME   |                                    |                     |                     |            |  |
|   | Tobias   | Mountain   |                 |                         | Louise                  | Louise Elbin  |                                    |                     |                     |            |  |
|   |  | IN U. S. ARMED FOR   |                 | SOCIAL SECURITY NO 17   | INFORMANT               |   |                                    |                     |                     |            |  |
| 111   | No   | il yes, give wor or object ov t  | etaice)         | None                    | Patien                  | t's chart.  | •                                  |                     |                     |            |  |
|   | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] . INTERVAL BE   |  |                 |                         |                         |   |                                    |                     | BETWEEN<br>ND DEATH |            |  |
|   | PART I. DEATH WAS CAUSED BY:   |  |                 |                         |                         |   |                                    |                     |                     | An DEVIL   |  |
|   | 260x DUE TO a a 1. To an I ami - orthogological  |  |                 |                         |                         |   |                                    |                     |                     |            |  |
|   | Conditions, if ony, which ) (b) 1/12 dece  |  |                 |                         |                         |   |                                    |                     |                     |            |  |
|   | gove rise to immediate   |  |                 |                         |                         |   |                                    |                     |                     |            |  |
|   | lying couse last   |  |                 |                         |                         |   |                                    |                     |                     |            |  |
| Z   | PART II. OTH   | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY |                 |                         |                         |   |                                    |                     |                     |            |  |
| MEDICAL CERTIFICATION   | 193 x  |  |                 |                         |                         |   |                                    |                     |                     | FORMED?    |  |
|   | 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED, (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                 |                         |                         |   |                                    |                     |                     |            |  |
| 3   | 20c. TIME OF INJURY  | Month, Doy, Yes  | or 20d. It      | NJURY OCCURRED 20e.     | PLACE OF INJURY (       | Home, form, 20f. (C   | City or town)                      | (Co                 | ounty)              | (Stote)    |  |
| AEDI  | Hour o.m.  | 19   | While of wor    | LAOL MINIS              | factory, street, office | e bldg., etc.)  |                                    |                     | • •                 |            |  |
| ~   | and the state of t |  |                 |                         |                         |   |                                    |                     |                     |            |  |
|   | 1 W  | 21. I certify that I attended the deceased from 12. 1934, to 12. 1935, that I last saw the deceased  |                 |                         |                         |   |                                    |                     |                     |            |  |
|   | alive of the causes and on the date stated above.  |  |                 |                         |                         |   |                                    |                     |                     |            |  |
|   | ACTUAL ADDRESS (Street, city or town, stole)  DATE SIGNED  |  |                 |                         |                         |   |                                    |                     |                     |            |  |
|   | SIGNATURE  | y cycc   | _M.D            | 7.007.00                | $m = \pm 1$             |   | 3-/-1                              | 4-1-20              |                     |            |  |
|   | PHYSICIAN'S<br>NAME (Type)   | 0 /  |                 |                         | Cus                     | mbul  | on pr                              | 121                 |                     |            |  |
| 220   | BURIAL CREMATION   | N, 225 DATE THEREC   | F               | 22c. NAME OF CEMETERY   | OR CREMATORY            | 22d. LO   | CATION (City, town,                | ar county)          | (5                  | fote)      |  |
|   | Firm tal   | KEMOYAL ISPECIAL   |                 |                         |                         |   |                                    |                     |                     |            |  |
| 23  | FUNERAL DIRECTOR'S   | SIGNATURE  |                 | ADDRESS                 |                         | 24a. REC'D BY REG   | ISTRAR 246 REGI                    | STPAR'S SIG         | NATORE -            | und        |  |
|   | Ruth E.  | Silcox   | Gumi            | berland Mar             | band                    | DATE AAV. 1. Q  | '58 Pts                            | Lean                | en                  |            |  |
|   |  |  |                 |                         |                         |   |                                    |                     |                     |            |  |



ADDRESS

24a, REC'D BY REGISTRAR

DATE

245 REGISTRAR'S SIGNATURE

Allegany c. CITY OR TOWN (If outside corporate timits, write RURAL and give nearest town) e. IS RESIDENCE ON A FARM? YES T NO Month 19 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS lost birthday) Months 12 CITIZEN OF WHAT COUNTRY U.S.A. Address Mrs. Robt. Edwards, Frostburg, INTERVAL BETWEEN Bronchial ASTKER. 20 YEARS. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED? YES TO NO TO 20f. (City or Jown) (County) (Slote) factory, street, office bldg., etc.) Hour o.m. Not while al wark of work 11415, 1958, that I last saw the deceased 21. I certify that I attended the deceased from and that death occurred at 130 P.M. From the causes and on the date stated above ADDRESS (Street, city or town, stote) ACTUAL Main St. prior PHYSICIAN'S John C. Devers, M. D. Frostburg. NAME (Type) 220 BURIAL, CREMATION, 226. DATE THEREOF 22c NAME OF CEMETERY OR CREMATORY 22d LOCATION (City, town, or county) Burial F'bg. Memorial Park Frostburg, Md.

Rea. Dist. No

ATTENDING FUNEZAL DIRECTOR: age 3 should be detac TO VS A15 (4) 15M 10/57

23. FUNERAL DIRECTOR'S SIGNATURE

J. R. Durst, Frostburg, Md.



TO HOSFITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death:

may be retained by the haspital ar attending physician.

TO FUNERAL DIRECTOR: Alti is certificate has been signed by the attending physician and campletely filled in by the funeral page 3 shauld be detached by use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 shauld be fulther registrar prior to burial, dremation, ar remaval, and in any event within 72 hours after death.

VS A15 (4) 15M 10/57

# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF BEATH

|  | 51   | 90                                     | CERT                                     | IFICA  | AIE OF DEF   | VIII                     |                                      | Reg. Dist. No | ),                                      |  |  |  |
|--|--|--|--|--|--|--------------------------|--------------------------------------|---------------|---|--|--|--|
| 1 PLACE OF DEATH o. COUNTY   | LEGANY   |  | MAR                                      | rland  | 2. USUAL RESIDENCE OF STATE ST V                   | (Where decear<br>IRGINIA | sed lived. If instituti<br>b. COUNTY |               | ore admission)                          |  |  |  |
| CUMBERLA   | is, write  | 2 DAYS                                 | IN 1b                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tow SPRINGFIELD |  |                          |                                      |               |   |  |  |  |
| OD INICTITUTION  | RIAL HOSPI   |  | dress)                                   |  | d. STREET ADDRE                                    | SS                       |                                      |               | e. IS RESIDENCE<br>ON A FARM?<br>YES NO |  |  |  |
| 3. NAME OF<br>DECEASED<br>(Type or print)  | FRA  |  | Middle                                   | _  | ELDS   | 4. DATE<br>OF<br>DEAT    | 4.4                                  |               | o 19 58                                 |  |  |  |
| 5. SEX<br>MALE   | 6. COLOR OR RACE WHITE   | WIDOWED                                |  | 0 🗆  | B. DATE OF BIRTH OCTOBER                           | 19                       | 9. AGE (In years lost-bighday)       | Months Days   | R IF UNDER 24 HRS.<br>Hours Min         |  |  |  |
| FARMING  | ON (Give kind of work<br>king life, even if retired  | done 10b KI                            | ND OF BUSINESS C                         | OR INDUS   |  | State or foreign         |                                      |               | S.A.                                    |  |  |  |
| HENRY FI   |  |  |  |  |  | RIA MC                   | ELFISH                               |               |   |  |  |  |
| 15 WAS DECEASED EVE<br>{Yes, no or unknown}  | R IN U. S. ARMED FOR   |  | OCIAL SECURITY NO                        | ). 17 R  | NEMORIAL HO  | SPITAL                   | - CUMBERL                            | AND, MAR      | YLAND                                   |  |  |  |
| Conditions, if or gove rise to it cause (o), storing lying couse lost.  PART II. OTH | my, which (b) mmediate the under-  | }                                      | NTRIBUTING TO DE                         | ATH BUT  | NOT RELATED TO THE T                               |                          | ASE CONDITION GIV                    |               | 19. WAS AUTOPSY PERFORMED? YES IN NO I  |  |  |  |
| OR CONTRIBUTING  | S UNDERLYING TO CAUSE OF DEATH MEDICAL EXAMINER)   | 206. DESCR                             | BE HOW INJURY O                          | CCURREC  | Enter nature of injur                              | y in Port I or P         | art If of item 1B)                   |               |   |  |  |  |
| 20c. TIME OF INJUR<br>Hour o. m.<br>p. m   | Y Month, Doy, Ye   | While of work [                        | URY OCCURRED Not white of work           | 20e, Pt#<br>foc  | ACE OF INJURY IHome,<br>tory, street, office bldg. | form, 20f. (Ci           | ity or town)                         | (County)      | (State)                                 |  |  |  |
| 21. I certify the alive on  ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)                 | 21. I certify that I attended the deceased from 1920, to 5-10, 1920, that I last saw the decease alive on 5-20, that I last saw the decease alive on 5-20, and that death occurred at 1:15 A.M., from the causes and an the date stated above ADDRESS (Street, city or town, state)  ACTUAL SIGNATURE SIGNATURE PHYSICIANS  DD 104410005 |  |  |  |  |                          |                                      |               |   |  |  |  |
| 220 BURIAL CREMANO<br>REMOVAL (Specify)<br>Burial<br>23 FUNERAL DIRECTOR             | 5-12-  | \\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | 22c. NAME OF CEM<br>Springfie<br>ADDRESS |  | ill Cem.   |                          | ATION (City, lown, inofield,         |               |   |  |  |  |

'58

Klannely



VS A15 (4) 15M 10/57 M

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, | 18 |
|--|----|
|--|----|

5191 CERTIFICATE OF DEATH

Reg. Dist. No. 187

| PLACE OF DEATH   | EGANY  |                    | MARYLA                | TATS a                                | RESIDENCE (WI                        | here deceased live                   | d. If institution<br>b. COUNTY | n. Residence b |             | sion)                              |
|--|--|--------------------|-----------------------|---------------------------------------|--------------------------------------|--------------------------------------|--------------------------------|----------------|-------------|------------------------------------|
| b CITY OR TOWN (I<br>RURAL and give no<br>CUMBERI                    | outside carparate fimileorest town)                      | s, write           | c. LENGTH OF STAY IN  | 3b c CITY                             |                                      | outside corporole l                  | limits, write RU               | RAL and give   | nearest low | n)                                 |
| d. NAME OF HOSPIT<br>OR INSTITUTION                                  | MEMORTATIONAL & WARWIC                                   | OSPIT<br>K AVE     | 姓(ess)<br><b>S・</b> , | 11 2                                  | NORTHM                               | ECHANIC                              | ST.,                           |                | ON.         | SIDENCE<br>A FARM?<br>NO \$        |
| 3. NAME OF<br>DECEASED<br>(Type or print)                            |  | ARY                | Middle 5.             |                                       | Lost<br>LK                           | 4. DATE<br>OF<br>DEATH               | Month                          |                | Doy<br>3    | Yeor<br>19 58                      |
| 5. SEX<br>FEMALE   | 6. COLOR OR RACE WHITE                                   | 7. MARRI<br>WIDOWE | DIVORCED              |                                       |                                      | , 1885                               |                                | Months Doy     |             | ER 24 HRS<br>Min                   |
| House T  | king I to, even if retired                               |                    | Own Home              |                                       |                                      | er foreign country                   |                                | U.S.           |             | COUNTRY?                           |
| 13. FATHER'S NAME DAVID  | KERR   |                    |                       |                                       | HER'S MAIDEN                         | Clarks                               | I O M                          |                |             |                                    |
| 15, WAS DECEASED EVE<br> Yes no. or unknown)                         | R IN U. S. ARMED FOR-<br>(If yes, give wor or doles of s |                    | SOCIAL SECURITY NO    | 17 INFORMANT                          | Folk                                 | the de-minute-site                   | Addre                          | n<br>cland     | Md.         |                                    |
| Canditions, if a gove rise to i couse (a), stating lying couse lost. | mmediate the under.                                      | 14                 | yporters / Barbers    | d Con                                 |                                      | Failer<br>roscle                     |                                |                | 10 ye       | ev-1                               |
| 200 ACCIDENT WA  | AS UNDERLYING []   |                    | RIBE HOW INJURY OCC   |                                       |                                      |                                      |                                | IN IN PART I(o | PERF        | NO                                 |
|  | Y Month, Doy. Yes  | while              | Not while             | e. PLACE OF INJU-<br>factory, street, | JRY (Home, forn<br>office bldg , etc | n, 20f (City or Id                   | own)                           | (Coun          | ty)         | (Stote)                            |
| 21. I certify the alive on 2.  | out 1 attended the may                                   | decease<br>_, 19_5 | ~ /                   | eath occurred                         | 122                                  | AM, from the ADDRESS (Street, S. Con |                                | nd on the i    | date stat   | deceased<br>ed above<br>ATE SIGNED |
| PHYSICIAN'S<br>NAME (Type)   | N. 122b. DATE THEREO                                     | £                  | Im. Marie of Co.      |                                       | un                                   | ferlos                               | 17                             | nd.            |             |                                    |
| BUP 181  | 5/6/58   |                    | Memorial              |                                       |                                      | Frost                                | burg,                          |                | (Sio        | te)                                |
| 23 FUNERAL DIRECTOR  | SIGNATURE  | 42                 | ADDRESS               | mires T                               | 240. REC'                            | AY 0 53                              | 24b~REGIST                     | PAR'S SIGNA    | TURE        |                                    |



# HEALTH DITT TO DEPUTY MEDICAL EXAMINER: This certificate shauld be executed within 24 haurs after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pendit in them, its. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded 1. \*\* Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained far your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Heat or its designated agent, prior to burial, cremotian, or removal, and in any event within 72 hours after death. M

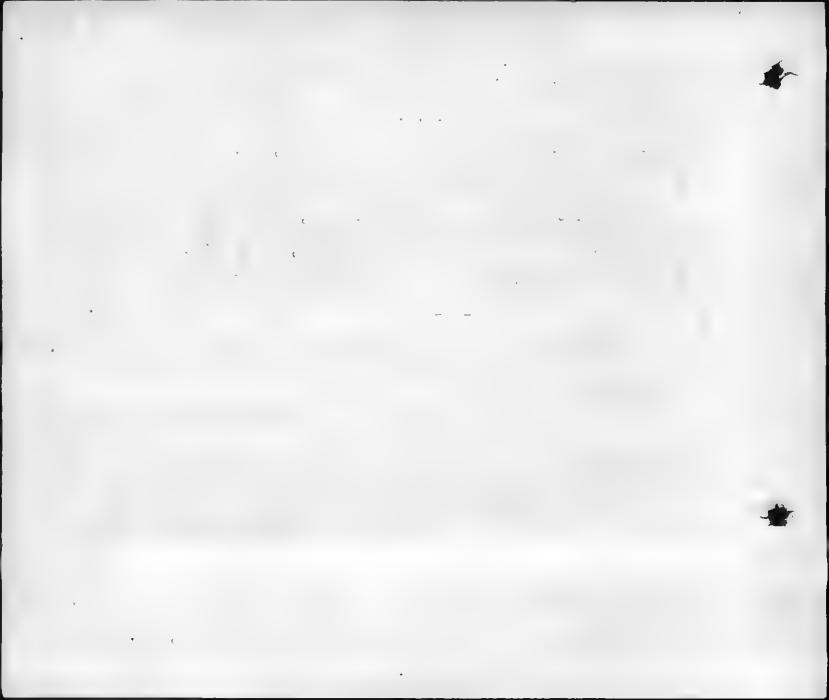
VS A15ME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05188

5 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No.

| ,  | 3. P          | LACE OF DEATH  |                                |                | and the second of the second o | 2. USUAL RESIDENCE (W           | There deceased lived. If insti | tution: Residence before admission)         |
|----|---------------|--|--------------------------------|----------------|--|---------------------------------|--------------------------------|---|
|    | ., 0          | A A  | llegany                        |                | MARYLAND   | o STATE Maryl                   | and 6 COUN                     | Allegany                                    |
|    | b             | CITY OR TOWN (If and give nearest town)                  | suis de corporate limits, well | #J#AL          | c. LENGTH OF STAY IN 16  | c. CITY OR TOWN (IF             | outside corporate I mits, writ | e RURAL and give nearest town)              |
|    |               | umberlan   |                                | If not in hour | D.O.A.   | Cumberla                        | ind                            | Te IS RE DIT E                              |
| ē  |               |  | _Hospita                       |                | onor, give street oodtess)   | 110 Utah.                       | St.                            | ON A FARM YES NO X                          |
|    | 3. h          | NAME OF  | Fire                           |                | Middle   | Lost                            | 4 DATE Mor                     | nth Day Year                                |
|    | t             | DECEASED<br>Type or print)                               | Hug                            | la .           | Albert   | Forquer                         | OF DEATH May                   | 6 1958                                      |
|    | 5. S          |  | . ,                            |                | D NEVER MARRIED 8  | 4                               | 9. AGE (In year)               | THUNDER TYEAR IT UNDER 24 HRS               |
|    |               | Male   | White                          | WIDOWED        |  |                                 | 915 42 yrs                     | Months Days Hours Min.                      |
|    | 10o.          |  | N (Give kind of work           | done 10b K     | IND OF BUSINESS OR INDUST  |                                 |                                | 12 CITIZEN OF WHAT COUNTRY                  |
|    | ,             | Contract   | or                             |                |  | Ponce. 1                        | Porto Rico                     |   |
|    | 13.           | FATHER'S NAME  |                                |                |  | 14. MOTHER'S MAIDEN N           | IAME                           |   |
|    |               | Francis  | Joseph F                       | orque          | r  | Lsaura '                        | Tossis                         |   |
|    | 15.           | WAS DECEASED EVE   |                                | RCES? 16 S     |  | IFORMANT                        | Addre                          | ts.   |
|    | 1142          | No   | (it yes, give war ar eases or  | 1              | 9-10-099100  | sephine For                     | rquer Johns                    | town, Pa.                                   |
|    |               |  | H Enter only one co            |                |  |                                 | <u> </u>                       | INTERVAL DETWEEN                            |
|    |               | PART I. DEATI  | H WAS CAUSED BY:               |                |  | alm at an                       |                                | ONSET AND DEATH                             |
|    |               | 11001  | IMMEDIATE CAUSE to             |                | Coronary Oc  | stratou                         |                                | 1 hr.                                       |
|    |               | 4.000  | DUE TO                         |                | 0 0 - 1  |                                 |                                |   |
|    |               | Conditions, if on<br>gove rise to immed                  |                                |                | Coronary Sc.   | Lerosis                         |                                |   |
|    |               | (a), stating the v                                       |                                |                |  |                                 |                                |   |
|    |               | couse lost.  | ) (c                           |                |  |                                 |                                |   |
| 6  | Š             | PART (I. OTH   | ER SIGNIFICANT CON             | DITIONS CO     | INTRIBUTING TO DEATH BUT N   | OT RELATED TO THE TERMI         | NALDISEASE CONDITION G         | VEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? |
|    | 3             |  |                                |                | pertrophy,   |                                 |                                | AR M HO                                     |
|    | CERTIFICATION | 200. EXTERNAL CAU<br>PRIMARY G or CON<br>CAUSE OF DEATH. | SE WAS<br>ITRIBUTING []        | DESCRIBE       | HOW INJURY OCCURRED (E   | nter noture of injury in Por    | t For Port II of Hem 18.)      |   |
|    |               | 20c TIME OF INJUR  | Y Month, Doy, Ye               | or 20d II      |  | CE OF INJURY (Home, form        |                                | (County) (Stote)                            |
|    | MEDICAL       | Hour a.m.  | 19                             | While          | Not white focts  | ory, street, office bldg., etc. | )                              |   |
|    | ^             |  | at I taak charge               |                | emains described obo   | ve, held on Autops              | y X, Inspection                | Inquiry X, and in my                        |
|    |               | opinion death  | resulted from:                 | Natural        | Buses 🔼 , Accident [   | ], Suicide [], I                | Hamicide 🔲, Unde               | termined manner                             |
|    |               |  | 1                              | . 1 (1         | ,  |                                 |                                |   |
|    |               | ACTUAL SIGNATURE Z                                       | Desse du                       | たしん            | starelice.   | M.D. CHIEF MEDICAL EX           | AMINER []                      | DATE SIGNED                                 |
|    |               | 73   | , <u> </u>                     |                |  | ASSISTANT MEDIC                 | AL EXAMINER []                 |   |
| ., |               | EXAMINER'S<br>NAME (Type)                                | agi e                          |                | tarelio  | DEPUTY MEDICAL                  |                                | May 6, 1958                                 |
|    | 220           | REMOVAL (Specify)  | N, 226. DATE THERE             | OF .           | 22c. NAME OF CEMETERY OR   |                                 | 22d, LOCATION (City, lown      |   |
|    |               | Burial   | 5/9/58                         |                | Grandview (  |                                 | Johnstown                      |   |
|    | 1             | FUNERAL DIRECTOR   |                                |                | ADDRESS  | 240 REC'                        | D BY REGISTRAR 246. REC        | GISTRAR'S SIGNATURE                         |
|    |               | William  | Moskal                         | Johns          | town, Pa   | DATE                            | MAY 8 58                       |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 haurs ofter death.

VS A15 (4) 15M 10/57

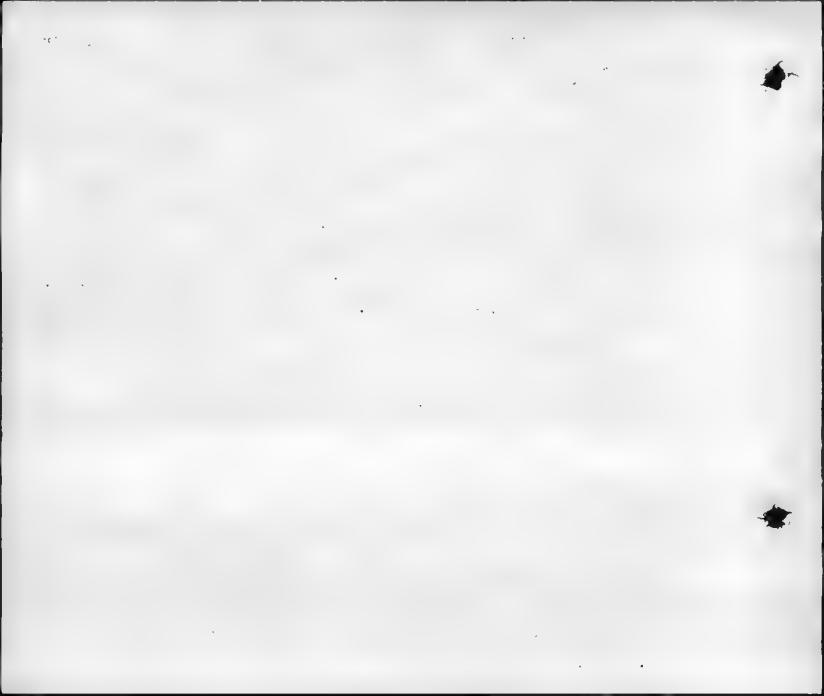
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05189

5193 CERTIFICATE OF DEATH

| Reg. | Dist | M-  |
|------|------|-----|
| NEG. | DIM. | MO. |

| 1. PLACE OF DEATH COUNTY Allegany MARYLAND  | 2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE Maryland b COUNTY Allegany   |
|---|--|
| b. CITY OR TOWN (# outside corporate limits, write RURAL and give nearest town)  Cumberland  c. LENGTH OF STAY IN 1b  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lown)  Cumberland   |
| d NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION 546 Fairview Avenue   | d STREET ADDRESS i 546 Fairview Avenue e. IS RESIDENCE ON A FARM? YES \( \sum \text{NO} \)   |
| 3. NAME OF DECEASED (Type or print) ARNOLD ROY FRAI   | NKLAND  A. DATE OF Play  OF DEATH  O |
| 5 SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DIVORCED DIVORCED   | 8. DATE OF BIRTH  9 AGE (In years   IF UNDER 1 YEAR IF UNDER 24 HRS   1981 pirthdoy)   1995   |
| 100 USUAL OCCUPATION (Give kind of work done during most of working life, even if refired) Night Watchman  13. FATHER'S NAME  LeRoy Frankland   | Westernport Maryland USA  Mrs. Roy Frankland 546 Fairview Aven   |
| 15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. It (Yes no. or unknown, Yes) 214-05-6431 M.  | NFORMANT  rs. Roy Frankland  Cumberland, Address rview Avenue  Cumberland, Maryland  |
| 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c)]  PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)  Conditions, if ony, which gove rise to immediate couse (o), stoting the under- tying couse lost.  (c) | clusion  Interval between onser and death  Several years   |
| 5 11. Diobetes meliting   | NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED? YES NO D. (Enter nature of injury in Port I or Part II of item 18.)   |
| 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED Hour o. m.   19   White Not white of work   19   19   | ACE OF INJURY (Home, form, 20f (City or town) (County) (Store) clory, street, office bldg., etc.)  |
| 21. I certify that I attended the deceased from 1950 alive an 1309 pril 1950, and that death ACTUAL Cautar Brusfull   | n accurred at 545 P. M., from the causes and an the date stated above  ADDRESS (Street, city or town, state)  May 15, 19  May 15, 19   |
| PHYSICIAN'S (ARLTO ) BRINSFIELD   | Simbulme Md.   |
| Burial (Specify) May 17, 1958 Hillcrest B   | (Sidile)   |
| 23. FUNERAL DIRECTOR'S SIGNATURE  ADDRESS  John J. Hafer, Cumberland, Maryland  | DATE AN 1 9 158  |



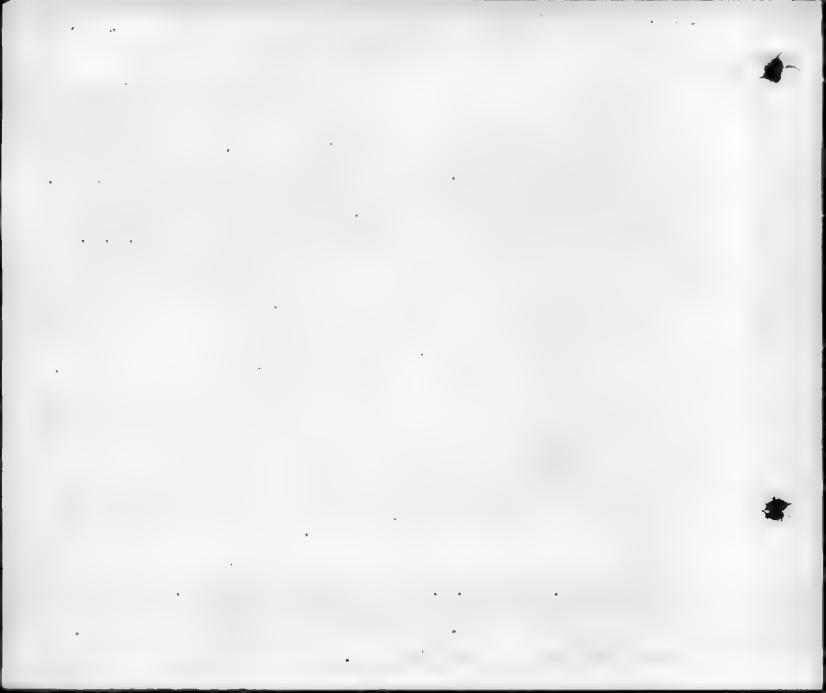
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5194 CERTIFICATE OF DEATH

Reg. Dist. No. 05191)

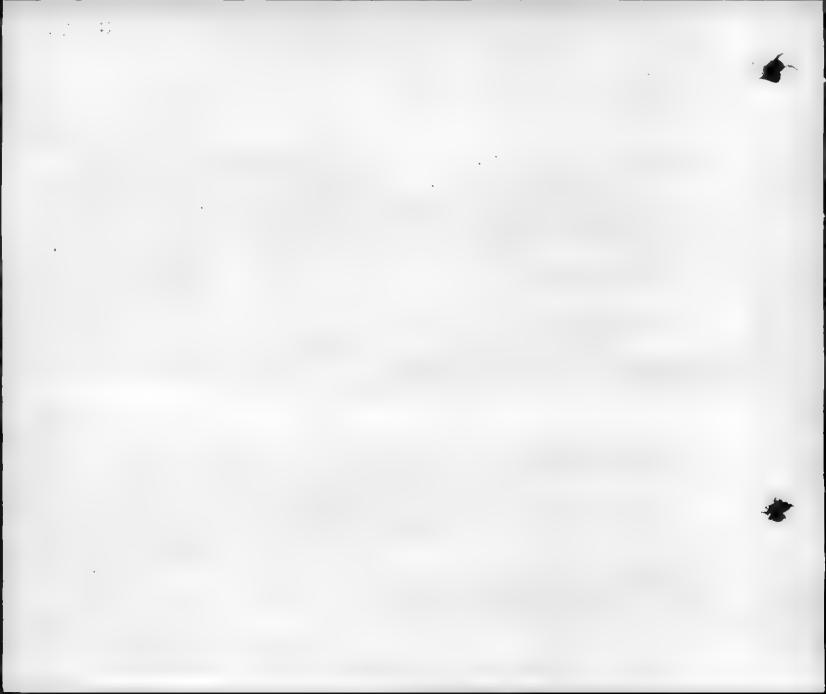
| Secred Heart Hospital    12  Badford St.   St.   Mooile   Doy   Year   Dockard   Nora   R.   Geary   Dark   May   16   1998.   |                                   |   |                            |          |                              |              |                       |              | 3 1701                             |
|--|-----------------------------------|---|----------------------------|----------|------------------------------|--------------|-----------------------|--------------|------------------------------------|
| Letty of Driving (Flow) do copporate limits, write   C. LENGTH OF STAY IN 16   C. CITY OF TOWN (If Counde corporate limits, write BURAL and give necretal town)    d. Letty of Driving (Flow) do copporate limits, write BURAL and give necretal town)    d. Letty of Driving (Flow) do copporate limits, write BURAL and give necretal town)    d. STREET ADDRESS   C. LIBERT ADDRESS   C. LIBERT ADDRESS    DO READ   DO READ   T. MARRIED   DOY 1620    Fremale   White   WOOWNED   DRIVER MARRIED   DOY 1620    Female   White   WOOWNED   DRIVER MARRIED   DRIVER |                                   |   | 44 4 6 V I A               | - 11     | . USUAL RESIDENCE (WI        | iere deceose | d lived If instituti  | on Residence | before admission)                  |
| b. CITY OR TOWN (Founds decoporate lamits, write SURAL and give nearest lown)  LURAL and the meterate lown)  LURAL and the meterate lown)  LURAL AND the meterate lown of the meterate lown of the meterate lown on the lural and the lur |                                   |   | MAKTLA                     | UND      | Marv                         | land.        | D. COOI411            |              | gany                               |
| Sacred Heart Hospital    12  Badford St  | b. CITY OR TOWN<br>RURAL and give | (If outside corporate limits, write nearest lown)                       | c. LENGTH OF STAY IN       | ТЪ       | c. CITY OR TOWN (IF          | utside corp  | Prote limits, write R |              |                                    |
| Sacred Heart Hospital    12  Badford St  | Cumb                              | erland  |                            |          |                              | berla        | nd                    |              |                                    |
| NAME OF DECRAPY    STATE   STA | OR INSTITUTION                    | TIME (IT not in hospilot, give street                                   | oddress)                   |          | d. STREET ADDRESS            |              |                       |              | e. IS RESIDENCE                    |
| DECEASED IT SPORT PIPOT   NOTE   R.   Geary   DEATH   May   16, 1958.  5 SEX   G COLOR OR RACE   7 MARRIED   DEVORCED   Tob   5 - 1877   SI DATE OF BIRTH   9 AGE (in, pren)   FUNDER 1968   DATE OF BIRTH   9 AGE (in, pren)   FUNDER 1978   DATE OF BIRTH   9 AGE (in, pren)   FUNDER 1978   DATE OF BIRTH   9 AGE (in, pren)   FUNDER 1978   DATE OF BIRTH   9 AGE (in, pren)   FUNDER 1978   DATE OF BIRTH   9 AGE (in, pren)   FUNDER 1978   DATE OF BIRTH   9 AGE (in, pren)   FUNDER 1978   DATE OF BIRTH   PART   DATE OF BIRTH   DATE |                                   |   |                            |          | 124 Bedfo                    | rd St        |                       |              | YES NO TE                          |
| Top copy print  Not  | 3 NAME OF<br>DECEASED             | First   | Middle                     |          | Lost                         |              | Mon                   | ith          | Day Year                           |
| Second   S   | (Type or print)                   | Nora  | R.                         |          | Geary                        | DEATH        | Mar                   | U*           | 76. 1958.                          |
| Female   White   Widows   Divorced   Fab   5 - 1877   81   72   100. USUAL OCCUPRION (Give kind of working life, even it retired)   Pab   School   Teacher   Maryland   U. S. A.   | 5. SEX                            | 6 COLOR OR RACE 7 MAR   | RIED NEVER MARRIED         | 8. 1     | DATE OF BIRTH                |              | 9 AGE (In years       | IF UNDER 1   |                                    |
| 100. USAL OCCUPATION   Give land of work done   100. KIND OF BUSINESS OR INDUSTRY   1 SHRHMACE (Stote or foreign country)   12. CHIZEN OF WHAT COUNTRY   Maryland   U. S. A.   | Female                            | White WIDOW   | ED DIVORCED                |          | L 1877                       |              |                       | Months D     | Days Hours Min                     |
| Retired School Teacher    Arthers name   | 10a. USUAL OCCUPAT                | ION (Give kind of work dane 10b.  | KIND OF BUSINESS OR        | INDUSTR  | Y 11 BIRTHPLACE (Stote       | or foreign c | ountry)               | 12. CITIZ    | EN OF WHAT COUNTRY                 |
| Martin Geary   Martin Geary   Martin Geary   Mary F Fitzpatrick  | During most of wo                 | rking lire, even ir retired)  |                            |          |                              |              | **                    |              |                                    |
| Martin Geary  15. WAS DECEASED EVER IN U. S. ARMED FORCES?  16. SOCIAL SECURITY NO. 17. INFORMANT Neighbor Mrs. Manley  18. CAUSE OF DEATH [Enter only one couse per line for [o], [b], and [c].]  PART I. DEATH WAS CAUSE BY  18. DUE TO Conditions, if any, which gove rise to immediate couse for immediate couse [o], staling the under [o] Lying couse [o].  19. The part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART Ite)  19. WAS AUTOCOURED [Enter nature of injury in Part I or Part II of item 18.]  20. TIME OF INJURY MADICAL EXAMINER;  20. TIME OF INJURY MADICAL EXAMINER;  21. I certify that I attended the deceased from July 9, 19.51, to May 16, 19.58, that I last saw the dece of injury in Part I of Street (County) and that death accurred of the County of Injury of Inju |                                   | Schoor Leacher  |                            |          |                              | IAME         |                       | 100          | D. R.                              |
| 13. WAS DECEASEDEVER IN U. S. ARNED FORCES?   16 SOCIAL SECURITY NO   17 INFORMANT   Neighbor Mrs. Manley   18   Neighbor Mrs. Mrs. Mrs. Mrs. Mrs. Mrs. Mrs. Mrs   |                                   | Martin Gears  |                            |          |                              |              | patrick               |              |                                    |
| Neighbor Mrs. Manley   Neighbor Mrs. Mrs. Mrs. Mrs. Mrs. Mrs. Mrs. Mrs   | 15. WAS DECEASED EV               |   | SOCIAL SECURITY NO         | 17 INFO  |                              |              |                       | P044         |                                    |
| Record Continued   | Yes, no. or unknown)              | (If yes, give war or dates of service)                                  |                            |          |                              | 3/3          |                       |              |                                    |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (c) COPOTARY Thrombosis 1 day  420.0 Due to  Conditions, if ony, which gove rise to immediate course (c), stating the under lying couse last.  (c) None  Part II. Other significant conditions contributing to death but not related to the terminal disease condition given in part 1(o) 17 Was autoin present the present of the terminal disease condition given in part 1(o) 18 Present was underlying and account of the terminal disease condition given in part 1(o) 19 Was autoin present was underlying and account of the terminal disease condition given in part 1(o) 19 Present was underlying and account of the terminal disease condition given in part 1(o) 19 Present was underlying and account of the terminal disease condition given in part 1(o) 19 Present was underlying and account of the terminal disease condition given in part 1(o) 19 Present was underlying and account of the terminal disease condition given in part 1(o) 19 Present was underlying and account of the terminal disease condition given in part 1(o) 19 Present was underlying and account of the terminal disease condition given in part 1(o) 19 Present was underlying and account of the terminal disease condition given in part 1(o) 19 Present was underlying and account of the terminal disease condition given in part 1(o) 19 Present was underlying and account of the terminal disease condition given in part 1(o) 19 Present was underlying and account of the terminal disease condition given in part 1(o) 19 Present was underlying and account of the terminal disease condition given in part 1(o) 19 Present was underlying and account of the terminal disease condition given in part 1(o) 19 Present was underlying and account of the terminal disease condition given in part 1(o) 19 Present disease and and the december of the terminal disease condition given in part 1(o) 19 Present was underlying and account of the terminal disease condition given in part 1(o) 19 Present was underlying and account of the terminal disease condition g |                                   |   |                            | N        | ergupor Mrs.                 | Manu         | .ey                   |              |                                    |
| DUE TO  Conditions, if ony, which gove rise to immediate couse (a), stating the under lying couse last.  Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOIN PERFORMED YES NOT  |                                   |   | ne for (a), (b), and (c).} |          |                              |              |                       |              | INTERVAL BETWEEN                   |
| Due to  Conditions, if ony, which gove rise to immediate course (o), stating the under. If ying course lost.  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) IP WAS AUTOUT PERFORMED YES NO)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) IP WAS AUTOUT PERFORMED YES NO)  OCCURRED THAN UNDERVING CAUSE OF DEATH OF COURSED NO.  OCCURRED THAN OTHER MODILEY MODILE EXAMINER NOTE  100 ETHER. NOTIFY MODILE EXAMINER NOTE  110 OF INJURY MONIK, DOY, Year 20d. INJURY OCCURRED NO.  While of work of work.  21. I certify that I attended the deceased from July 9. 1951, to May 16. 1958, that I last saw the dece olive an May 16. 1958, and that death occurred of the Street Signature ADDRESS (Street, city or lown, stole)  ACTUAL SIGNATURE OF MATTER OF BENEAU CREMATION. 276. DATE THEREOF STEEL NAME OF CEMETERY OR CREMATORY 172 DECEMBER. ADDRESS (Street, city or lown, stole)  STEMOVAL (Specify) 5/19/58 St. Mary's Cemetery Lenacening Ma.  ADDRESS SIGNATURE  ADDRESS SIGNATURE  ADDRESS SIGNATURE  240. RECCD BY REGISTRAR 7246 REGISTRAR'S SIGNATURE  240. RECCD BY REGISTRAR 7246 REGISTRAR'S SIGNATURE  |                                   | IMMEDIATE CAUSE (o)   | Coronary Thr               | ombo     | sis                          |              |                       |              |                                    |
| gove rise to immediate couse (a), stating the under lying couse (as). None  Part II. Other significant conditions contributing to death but not related to the terminal disease condition given in part 1(a) 19 Was autoly performed age  200. ACCIDENT WAS UNDERLYING Advanced age  200. ACCIDENT WAS UNDERLYING CAUSE OF DEATH IN FIRST PART (B) 19 Was autoly performed by the contribution of the part II. Other nature of injury in Port I or Port II of item 18.)  200. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED While of work of wo | 420.0                             |   |                            | -        |                              |              |                       |              |                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) IF WAS AUTO PERFORMED YES NO.  Advanced age  200. ACCIDENT WAS UNDERLYING DORIGH CAUSE OF DEATH IN FORTH OF PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) IF WAS AUTO PERFORMED YES NO.  200. ACCIDENT WAS UNDERLYING DORIGH CAUSE OF DEATH OF PROTOCOLOR OF PERFORMED YES NO.  200. ACCIDENT WAS UNDERLYING DORIGH CAUSE OF DEATH OF PART II. OTHER II. OF II | Conditions, if                    | ony, which )  | Arterioscler               | otic     | Heart Disea                  | ase          |                       |              | 20 vr.                             |
| Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) PREFORMED  Advanced age  200 ACCIDENT WAS UNDERLYING DEATH CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) PREFORMED  VES NOT ON CONTRIBUTING DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) PREFORMED  VES NOT OF CONTRIBUTING DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) PREFORMED  VES NOT OF CONTRIBUTING DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) PREFORMED  VES NOT OF CONTRIBUTING DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) PREFORMED  VES NOT PROFORMED  VES NOT PREFORMED  VES NOT PREFORMED  VES NOT PREFORMED  VES NOT PROFORMED  VES NOT PROFO | gove rise to                      | immediale (   |                            |          |                              |              |                       |              |                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOO PERFORMED YES NOT NOT CONTRIBUTING OF CONTRIBUTION OF CONTRIBUTING OF CONTRIBUTING OF CONTRIBUTING OF CONTRIBUTION OF CONTRIBUTI |                                   | g the Under-  | Vone                       |          |                              |              |                       |              |                                    |
| Advanced age    Performed   Pe |                                   |   | CANTRIBUTIALS TO DEATH     | A DUT NO | T DELLATED TO THE TOUR       |              |                       |              |                                    |
| 20c. TIME OF INJURY Manth, Doy, Year 20d. INJURY OCCURRED While of work of wor | E                                 |   | ONING TO DEAT              | BUINC    | I KELATED TO THE TERMI       | NAL DISEAS   | E CONDITION GIV       | EN IN PART 1 | 1(a) 19 WAS AUTOPSY<br>PERFORMED?, |
| 20c. TIME OF INJURY Manth, Doy, Year 20d. INJURY OCCURRED While of work of wor | 2                                 |   |                            |          |                              |              |                       |              | YES NO                             |
| 21. I certify that I attended the deceased from July 9. 1951, ta May 16. 1958, that I last saw the deceased of the last saw the dece |                                   | VAS UNDERLYING ☐ 206. DESI<br>G ☐ CAUSE OF DEATH<br>Y MEDICAL EXAMINER) |                            | URRED. ( | Enter nature of injury in P  | ort I or Por | t II of item 1B.)     |              |                                    |
| 21. I certify that I attended the deceased from July 9. 1951, ta May 16. 1958, that I last saw the deceased of the May 16. 1958, that I last saw the deceased of the May 16. 1958, and that death occurred of the 15 PM, from the causes and on the date stated at ADDRESS (Street, city or town, state)  ACTUAL ACTUAL SIGNATURE  M.D. 110 Bedford Street  M.D. 110 Bedford Street  M.D. 110 Bedford Street  MARY 16. 1958, that I last saw the deceased from July 9. 1951, ta May 16. 1958, that I last saw the deceased from May 15. 1958, that I last saw the deceased from May 15. 1958, that I last saw the deceased from May 15. 1958, that I last saw the deceased from May 15. 1958, that I last saw the deceased from May 15. 1958, that I last saw the deceased from May 15. 1958, that I last saw the deceased from May 15. 1958, that I last saw the deceased from May 15. 1958, that I last saw the deceased from May 15. 1958, that I last saw the deceased fro | 3 20c. TIME OF INJU               |   | VJURY OCCURRED 20          | e. PLACE | OF INJURY (Home, form,       | 20f. (City   | or town)              | ICo.         | ounty) (Stote)                     |
| 21. I certify that I attended the deceased from July 9. 1951, ta May 16. 1958, that I last saw the deceased of the last saw the dece | Hour o.m.                         |   | Not while                  | factor   | , street, office bldg., etc. | 1            |                       | 100          | only) (side)                       |
| olive an May 16.  19 50, ond that death occurred of 4-15 P.M., from the causes and on the date stated of Address (Sireet, city or lown, stote)  ACTUAL SIGNATURE  M.D. 110 Bedford Street  M.D. 110 Bedford Street  M.D. 110 Bedford Street  MAY 16.  17 58  PHYSICIAN'S James P. Hallinan M. D.  Cumberland, Maryland.  Cumberland, Maryland.  18 50 NAME (Type)  19 50 NAME OF CEMETERY OR CREMATORY  BUT 11 Specify)  St. Marys Cemetery  19 40 REGISTRAR'S SIGNATURE  ADDRESS  240 REGISTRAR'S SIGNATURE   |                                   | 01 #01  |                            |          |                              |              | 75                    |              |                                    |
| olive an May 16.  19 50, ond that death occurred of 4-15 P.M., from the causes and on the date stated of Address (Sireet, city or lown, stote)  ACTUAL SIGNATURE  M.D. 110 Bedford Street  M.D. 110 Bedford Street  M.D. 110 Bedford Street  MAY 16.  17 58  PHYSICIAN'S James P. Hallinan M. D.  Cumberland, Maryland.  Cumberland, Maryland.  18 50 NAME (Type)  19 50 NAME OF CEMETERY OR CREMATORY  BUT 11 Specify)  St. Marys Cemetery  19 40 REGISTRAR'S SIGNATURE  ADDRESS  240 REGISTRAR'S SIGNATURE   | 1                                 | A   |                            | <b>3</b> | . 19 <u>51</u> , to May      | 16,          | 19.58                 | "that I la   | ist saw the decease                |
| ACTUAL SIGNATURE ADDRESS (Street, city or town, stote)  ACTUAL SIGNATURE ADDRESS (Street, city or town, stote)  M.D. 140 Bedford Street 5-17-58  PHYSICIAN'S James P. Hallinan M. D. Cumberland, Maryland.  Cumberland, Maryland.  Cumberland, Maryland.  Cumberland, Maryland.  Comparison of Comparison (City, town, or county)  St. Marys Cemetery Lenacening, Md.  Comparison of Comparison (City, town, or county)  St. Marys Cemetery Lenacening, Md.  Comparison of Comparison of Comparison (City, town, or county)  Comparison  | olive an Ma                       | y 16.   | ond that de                | eath o   | curred ot 4.15 I             | M, fror      | n the causes a        | nd on the    | date stated above                  |
| PHYSICIAN'S James P. Hallinan M. D. Cumberland, Maryland.  220 BURIAL CREMATION, 22b. DATE THEREOF REMOVAL (Specify) 5/19/58 St. Marys Cemetery (Steel) Lenacening, Md.  23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24a. REC'D BY REGISTRAR'S SIGNATURE  | 0                                 | 1   | s lan                      | 1        |                              | ADDRESS (S   | treet, city or town,  | stote)       | DATE SIGNE                         |
| PHYSICIAN'S James P. Hallinan M. D. Cumberland, Maryland.  220 BURIAL CREMATION, 22b. DATE THEREOF St. NAME OF CEMETERY OR CREMATORY  BUT 121  23. FUNERAL DIRECTOR'S SIGNATURE  240. REC'D BY REGISTRAR 24b REGISTRAR'S SIGNATURE   | ACTUAL                            | mest. Na  | ienan mi                   | ~        |                              |              |                       |              | 5_17_58                            |
| NAME (Type) USINGS F. HALLINGH FI. D. CUMBERTARY, FIATYLAND.  220 BURIAL CREMATION, 22b. DATE THEREOF ST. NAME OF CEMETERY OR CREMATORY 22d LOCATION (City. tawn. or county) (State)  BUT121 St. Marys Cemetery Lenacening Md.  23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24o. REC'D BY REGISTRAR'S SIGNATURE   |                                   |   |                            | M.D      |                              |              |                       |              |                                    |
| BUTIAL 5/19/58 St. Marys Cemetery Lenacening Md.  23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 240. REC'D BY REGISTRAR'S SIGNATURE   | PHYSICIAN'S<br>NAME (Type)        | James P. Halling  | an M. D.                   |          | Cumberlar                    | nd, Ma       | ryland.               |              |                                    |
| Burial 5/19/58 St. Marys Cemetery Lenacening, Md.  23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 240. REC'D BY REGISTRAR'S SIGNATURE  | 220 BURIAL CREMATIC               | ON, 22b. DATE THEREOF   | 22c NAME OF CEMETE         | RY OR C  | REMATORY                     | 229 TOCY     | TION (City, town, o   | or county)   | (State)                            |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 240. REC'D BY REGISTRAR 246 RECISTRAR'S SIGNATURE   | Burial                            | 5/19/58   | St. Marv                   | s Ce     | emeterv                      | -            | -                     |              |                                    |
|  | 23. FUNERAL DIRECTO               | R'S SIGNATURE   |                            |          |                              |              |                       |              |                                    |
| Daniel S 1 20 100 Coston   | George I                          | Sichherm 1  | onaconing                  | , 1      | Id. DALAY                    |              | E 3 A                 | educh        | <b>'</b>                           |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death yst ar attending physician. Use the ottending physician and campletely filled in by the funeral as sertificate has been signed by the ottending physician and campletely filled in by the funeral of use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 should be remained, and in any event within 72 hours offer death. may be retained by the hospi TO FUNERAL DIRECTOR: Aff page 3 should be detached... the registrar prior to burial, d VS A15 (4) 15M 10/57



| 1   | MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  |        |
|---|--|--------|
| 4 2.6   | 5232 CERTIFICATE OF DEATH Rog. Dist. NO.5191   |        |
| 000   | PLACE OF DEATH  o. COUNTY  Allegary  MARYLAND  2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  b. COUNTY  Allegary  MARYLAND  |        |
| death.  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  RURAL and give nearest town)  Frestburg  C. LENGTH OF STAY IN 1b  Lenacening   |        |
| by the 12 shou  | d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  Miners Hespital  Charek Street  * Is RESIDEN ON a FARK YES \( \sum NO   | W3     |
| 24 havr   | NAME OF DECEASED CHRISTINE Middle Last 4. DATE Month Day Year OF DEATH 5/31/1958 19  |        |
| d within 2<br>letely fille<br>s. Pages  | SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF SIRTH 9. AGE (In yours IF UNDER 1 YEAR IF UNDER 24  | HRS.   |
| ond comple  | As. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country)  House Work Own Nome  Lengening MD.  12. CITIZEN OF WHAT COU  | INTRY? |
| de a partie   | John Crosgrove Wagner  |        |
| certifi<br>ig phy<br>remo<br>72 hou   | (ex. no. or unknown)  No  No  No  No  No  No  No  No  No  N  |        |
| requires that the death ion. In signed by the attendir nsit permit. Then please and in any event within | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)  DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.  (c)   | EN TH  |
| The faw r<br>physicio<br>has been<br>riol-trans<br>moval, ar  | PART 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTO PERFORMED YES NO  | D?     |
| ittending<br>rifficate<br>is the bu   |  |        |
| PHYSI<br>fol or of<br>his cen<br>fremotio   | 20c. TIME OF INJURY Month, Day, Year Hour o. st. 19 While at work at w | ilate) |
| ined by the hasp<br>DIRECTOR: All<br>Id be defacthed<br>prior to burial,                                | 21. I certify that I attended the deceased from 12 1, 19, to 3/166, 19, that I last saw the deceased on 19, and that death occurred at 12 16 16 MM, from the causes and on the date stated at ADDRESS (Street, city or town, stote)  ACTUAL SIGNATURE 10 16 16 16 16 16 16 16 16 16 16 16 16 16  | bove.  |
| RAL shou stror  | PHYSICIAN'S NAME (Type) 14, AKTIN 4, RELIES ICIN PIO. EALLISTED ST. L.C.   |        |
| moy be of the registre  | REMOVAL (Specify)  Burial 6/3/1958  22c. NAME OF CEMETERY OR CREMATORY  Oak Mill Cemetery  Longoning, MD.  (Stote)   |        |
| VS A15 (4)  | GEORGE EICHHORN, LONACONING, MD.  240. REC'D BY REGISTRAR 246. REGISTRAR'S SIGNATURE DAYSIN 4 '58  |        |



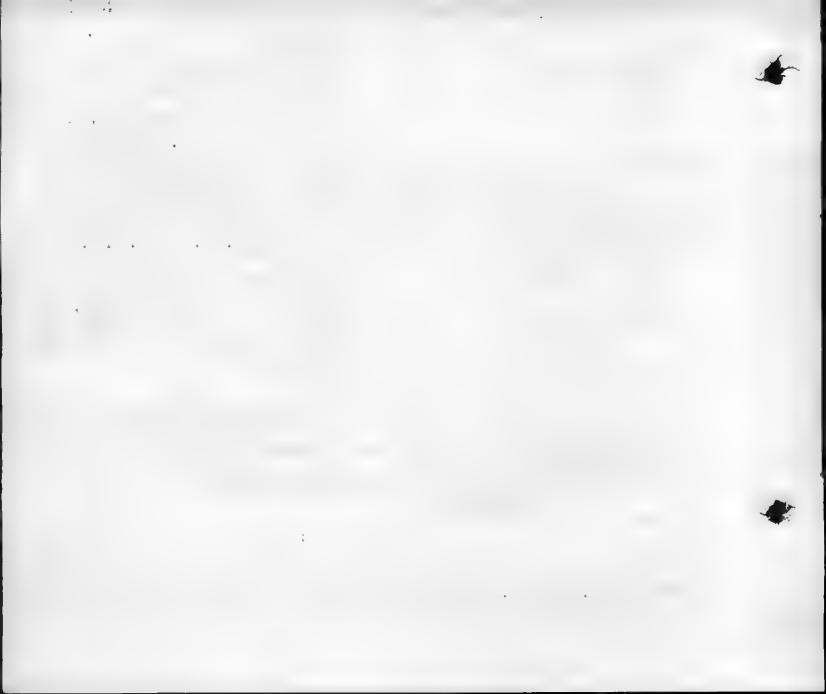


death.

the death certificate

PHYSICIAN:





05195

| 100 | CERTIFICATE | OF | DEAT |
|-----|-------------|----|------|
| 100 |             | •  |      |

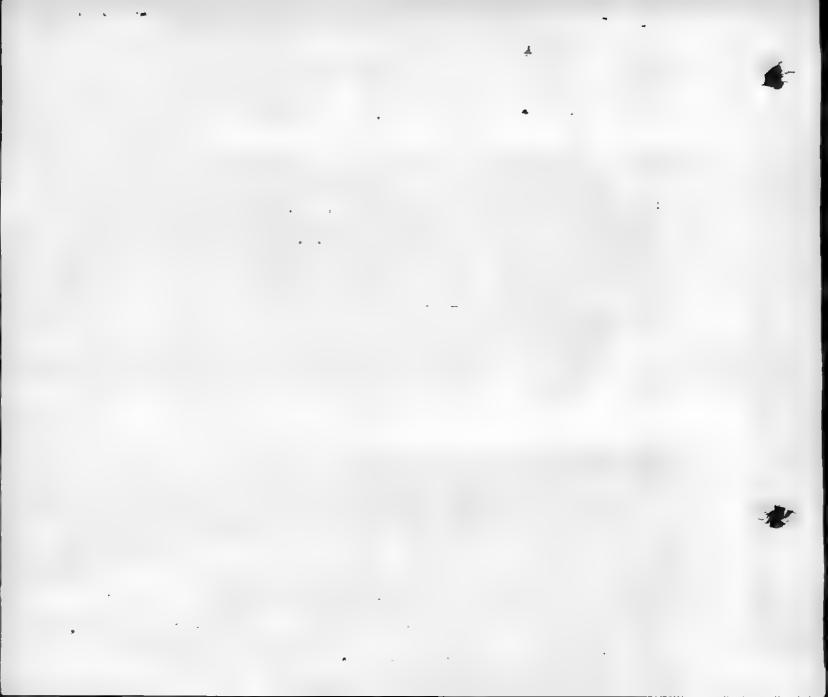
| 100 | CERTIFICATE | OF DEATH   |
|-----|-------------|------------|
| 100 |             | O. D-0.111 |

|   | 5198  | CENTILIES                           | TIL OI DEAT   |  | Reg. D                                | list. No.        |                          |
|---|---|-------------------------------------|---|--|---------------------------------------|------------------|--------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY  | Allegany  | MARYLAND                            |   | rland b                                      | . COUNTY A                            | llegan           | 7                        |
| RURAL and give nec  | outside corporote limits, write prest lown)  orland                         | LL/2/58                             | c. CITY OR TOWN (IF   | outside corporate fin                        | iits, write RURAL and                 | give nearest tow | /n }                     |
| OR INSTITUTION  | gany County   | Infirmary                           | d. STREET ADDRESS<br>RFD#                                   | 1, Box :                                     | 101                                   | ON               | SIDENCE<br>A FARM?<br>NO |
| NAME OF<br>DECEASED<br>(Type or print)  | First<br>Ida  | Middle<br>Ma e                      | Hughes  | 4. DATE<br>OF<br>DEATH                       | Month<br>May                          | 2,               | Year<br>1958             |
| Female  | 6. COLOR OR RACE 7. MAR   | ED K                                | 8. DATE OF BIRTH 5/29/1875                                  | lost   | E (In years birthday) B2 yrs. IF UNDE | Days Hours       |                          |
| 0a. USUAL OCCUPATION during most of works House                                     | N (Give kind of work done 10b. ing life, even if retired) WIFE              | KIND OF BUSINESS OR INDU            | STRY II BIRTHPLACE (Stone Maryla                            |  | 12 CI                                 | U. S.            |                          |
| 3. FATHER'S NAME  | ames Hitchin  | 18                                  | 14 MOTHER'S MAIDEN Mary A                                   | name<br>nn Steve                             | ens                                   |                  |                          |
| 5 WAS DECEASED EVER   | IN U. S ARMED FORCES? 16.   |                                     | Allegany Co   |  | Address C                             | umberla          | -                        |
| PART 1 DEAT   | TH (Enter only one couse per li H WAS CAUSED BY: IMMEDIATE CAUSE (c) DUE TO |                                     | enary Thy   | postas                                       | no<br>it                              | INTERVAL B       | FTWFFas                  |
| Conditions, if on<br>gave rise to im<br>couse (a), stating the<br>lying cause lost. | be under-   | Cerebra                             | il ait  | trios  | cleusi                                |                  | ?                        |
| Š   | ER SIGNIFICANT CONDITIONS   | Deteris                             | NOT RELATED TO THE TERM                                     |  | DITION GIVEN IN PA                    |                  | DRMED?                   |
| . 1   | CAUSE OF DEATH  | CRIBE HOW INJURY OCCURRE            | D (Enter noture of injury in                                | Part 1 or Part 11 of it                      | lem 18.)                              |                  |                          |
| 20c. TIME OF INJURY<br>Hour u.m.<br>p. m.   | Month, Day, Year 20d. li<br>White<br>at wor                                 | Not white for                       | ACE OF INJURY (Home, for<br>ctory, street, office bldg., et | m. 20f. (City or tow                         | n)                                    | (Counly)         | (State)                  |
| actual SIGNATURE  | of I attended the decease 1/58 19 19 19 19 19 19 19 19 19 19 19 19 19       | and that death                      |   | AM, from the ADDRESS (Street, citence Street | causes and an i<br>by or lown, state) | the date stat    |                          |
| 20. BURIAL CREMATION<br>REMOVAL (Specify)   |   | 20. NAME OF CEMETERY OF F bg. Memor | R CREMATORY   | and, Man                                     | ity, town, or county)                 | (Sto<br>Md       |                          |
| Burial  Burial  Burial  Burial  |   | ADDRESS Memor                       |   | 'D BY REGISTRAR                              | 246 REGISTRAR'S SI                    |                  | •                        |
| Joseph R.   | Durst. F  | rostburg. Md                        | DATE  | MAY 5 '58                                    | 000                                   | - 1              |                          |

TO HOSPITAL OR ATTENDING PHYSICIAN: The flow requires that the death certificate by exemuted within III haurs often death. Pege 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: At the first certificate has been signed by the attending physician and campletely filled in by the funeral page 3 shauld be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be fired with the registrar prior to burial, crematian, ar remaval, and in thy event within 72 hours after death. VS A15 (4) 15M 10/57





200. ACCIDENT WAS UNDERLYING OF CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

NAME (Type)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port II of item 18.)

20c. TIME OF INJURY Month. Day, Year 20d. INJURY OCCURRED Hour o. m. Not while of work of work

20e PLACE OF INJURY (Home, form, 20f. (City or town) factory, street, office bldg., etc.)

(County) (Stole)

(State)

YES NO

21. I certify that I attended the deceased from April 22. 1958 toMay "that I last saw the deceased \_\_\_\_, and that death accurred at 12:10p M, from the causes and an the date stated above.

ACTUAL SIGNATURE PHYSICIAN'S Wyand F. Doerner, Jr., M.D.

Algonquin Hotel, Cumberland, Maryland,

220 BURIAL, CREMAT ON, 226. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) Zion Memorial Burial Park Eurial 23. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 

22d, LOCATION (City, town, or county) Cumberland, Maryland

H. Wayne George Cumberland, lld. 24a, REC'D BY REGISTRAR 246 REGISTRAR'S SIGNATURE

law requires that the death certificate gned by permit. been signed or attending physician, i certificate has been signed as the bur althronsit p ő ö 80 may be retained by FUNERAL DIRECTO Page 3 should be de the registrar prior to 9

be

the fun should

campl

pup

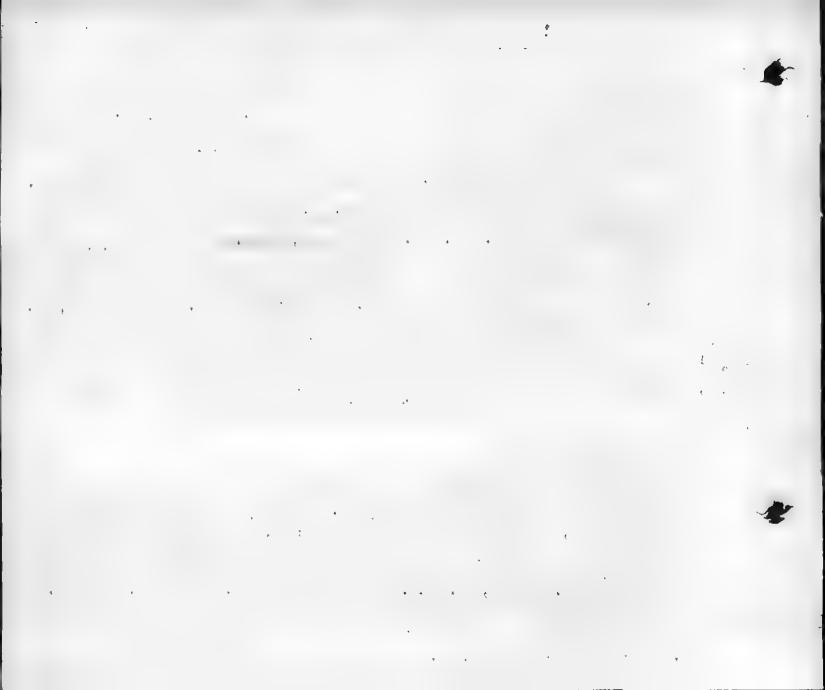
physician

Buipu

<u>a</u>

the The

VS A15 (4) 1SM 10/57



**CERTIFICATE OF DEATH** 5233 PLACE OF DEATH D. COUNTY Maryland Allegany MARYLAND b. CITY OR TOWN (If outside corporate limits, write E. LENGTH OF STAY IN 16 Frostours Gilmore should d. NAME OF HOSPITAL (If not in hospital, give street oddress) d. STREET ADDRESS or INSTITUTION Miners Hospital 61 NAME OF First Middle 4. DATE Last DECEASED OF DEATH william KELLEN (Type or print) 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH White WIDOWED [] February 1,1897 DIVORCED T complet papers. 10a. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (Stole or foreign country) during most of working life, even if refired)

TORE

[Lonaconing - Marv Lonaconing. 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME Henry Keller Cora Schaffer 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT William Keller Mrs. no none 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY nurunestes IMMEDIATE CAUSE (a) DUE TO permit. Conditions, if ony, which gave rise to immediate DUE TO couse (a), stating the underansit. lying cause lost. and CERTIFICATION 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY 20e. PLACE OF INJURY (Home, form, Doy, Year 20d. INJURY OCCUPRED 20f. (City or town) factory, street, office bldg., etc.) Hour o.m. Not while, at work at work 21. I cortify that I attended the deceased from Airy 6. ACTUAL SIGNATURE ERAL DIREC I should be pistrar prior BRUAD CURS FUNERAL C PHYSICIAN'S NAME (Type) MARION MIRCIASIEUR FOOD 220. BUR AL CREMATION, 22b. DATE THEREOF REMOVAL (Specify) Vale Summit Cemetery 5/14/58 O

05198

Reg. Dist. No. 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. COUNTY Allegany c. CITY OR TOWN (If autside corporate limits, write RURAL and give negrest town) e. IS RESIDENCE ON A FARM? YES NO Month Day 195 1 9. AGE (In years IF UNDER I YEAR IF UNDER 24 HRS (petroirthday) Months 12. CITIZEN OF WHAT COUNTRY? Marylan d U.S.A. Address Gilmere, Md. INTERVAL BETWEEN ONSET AND DEATH Chor PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 PERFORMED? YES NO 🗔 206 DESCRIBE HOW INJURY OCCURRED (Enter nature of unjury in Part I or Part II of item 18.) (County) (State) ..... 1950, to MA - 12 ..... 1950, that I last saw the deceased \_\_, and that death accurred at 4.40 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 22d. LOCATION (City, town, or county) (Stote) Vale Summit ADDRESS 23 FUNERAL DIRECTOR'S SIGNATURE 240. REC D. BY REGISTRAR 246 REGISTRAR'S SIGNATURE red - educh George Eichhorn Lonaconing. 16 DATE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

VS A15 (4)



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5234 **CERTIFICATE OF DEATH** Reg. Dist. No. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o COUNTY b. COUNTY Allegany MARYLAND Allegany b. CITY OR TOWN (If outside corporate limits, write the funera c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) RURAL and give nearest fown) wks. Frostburg Frostburg d. NAME OF HOSPITAL (If not in hospital, give street oddress)
OR INSTITUTION d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NOT Miners Hospital Blair Street NAME OF DECEASED First Middle 4. DATE Month Year (Type or print) DEATH FLORENCE ET.TZA BETH LANGAN 1958 6. COLOR OR RACE 7. MARRIED T NEVER MARRIED T 5. SEX 8. DATE OF BIRTH 9. AGE (In years last birthdoy) IF UNDER I YEAR IF UNDER 24 HRS Months Doys Hours camplet DIVORCED [ WIDOWED TH 10-21-1870 YES 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. 8IRTHPLACE (Slote or foreign country) 12 CITIZEN OF WHAT COUNTRY during most of working life, even if retired Housework Own Home New York City U.S.A. 3. FATHER'S NAME 14. MOTHER'S MAIDEN NAME physician haurs o John Bishop Unknown IS. WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO 17, INFORMANT Address IVes no or unknowns (If yes, give wor or dates of service) attending p lichael Manley, 10 Blair St. Frostburg, 18. CAUSE OF DEATH [Enter only one cause per line for (a), /b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO Canditions, if ony, which gove rise to immediate **DUE TO** cause (a), stating the underlying cause last, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19, WAS AUTOPSY PERFORMED? YES T NO 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c TIME OF INJURY Month, 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) Doy, Year (County) (Stote) Haur a. m factory, street, affice bldg , etc.1 Not while at work at work 1958 that I last saw the deceased 21. I certify that I attended the deceased from and that death accurred at 109 H M, from the causes and on the date stated above. ADDRESS (Syfeet/suty or town, state) DATE SIGNED ay be retained by FUNERAL DIRECT ACTUAL SIGNATURE 3 should PHYSICIAN'S NAME (Type) 220. BURIAL CREMATION 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d LOCATION (City, town, or county) (State) REMOVAL (Specify) Michael's Cemeterv ruria. Frostburg 0 245 REGISTRAR'S SIGNATURE VS A15 (4) DATE 1SM 10/57 ain. Frostburg. Md



## FOR STATE HEALTH DEPT.

I

THE DEPUTY MEDICAL EXAMPLES: This cert finate should be exemited within 24 horms after death. If any delay is necessory, pleas execute the certificate, within the word "pending" in pendit in flem 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 should be forwarded the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your fill 10 FUNERAL DIRECTOR: Fage 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Heavir 1st designated agent, prior to burial, cremation, or removal, and in any event within 72 hours ofter death.

VS. ATSME 5M 2/57

### MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No.

05200

|    |   | LACE OF DEATH                             | =0.44                                       | 4                |  | 2. USUAL RE        | NOENCE (Where deced      | ned lived If instituti   | ion Residence br                        | efore admission)               |
|----|---|---|---|------------------|--|--------------------|--------------------------|--|---|--------------------------------|
|    | 0   | . COUNTY A1                               | legany                                      |                  | MARYLAND   | o. STATE           | Maryland                 | b. COUNTY  | Allegar                                 | nv                             |
| 1  | þ   | . CITY OR TOWN gire                       |   | e RUFAL          | C. LENGTH OF STAY IN 16  | c CITY OF          | TOWN (If outs'de co      | rporate limits, write R  |   |                                |
| /  |   | fiile Lane                                | Road  |                  |  | Y                  | Mt Corroge               |  |   |                                |
|    | d   |   |   | If not in hospi  | ital, give street address)   | d STREET           | Mt. Savage               | J  |   | e IS RESIDENCE                 |
| )  |   | 12 hile W                                 | est of Wcl                                  | 1ersbu           | ırg  | Ne                 | w Row_                   |  |   | YES NO                         |
|    | [   | NAME OF<br>DECEASED                       | Fie   | rst              | Middle   | Los                | OF                       | Month  | Doy                                     | Yeor                           |
|    |   | Type or print)                            | Penjamir                                    | -                | Lashley  |                    | DEATH                    | hay 2  | 12.                                     | 19 58                          |
|    | 5. S  | ĒΧ  | 6. COLOR OR RACE                            | 7. MARRIED       | NEVER MARRIED . 8.   | DATE OF BIRTH      | 1                        | A 44 45 4 4  | Months Days                             | Hours Min.                     |
|    |   | Male                                      | White                                       | WIDOWED          | DIVORCED [   | Mar. 2             | 9, 1389                  | 69 yrs   | Months Days                             | nours Min.                     |
|    | 10a.  | . USUAL OCCUPATION uring most of working  | N (Give kind of work life, even if relired) | done 10b Kil     | ND OF BUSINESS OR INDUSTI  | RY 11. BIRTHPE     | ACE (State or foreign    | Country)   | 12 CITIZEN C                            | F WHAT COUNTRY?                |
|    |   | etired l'oi                               |   | F                | Railroad   | Art                | emas, Pa.                |  | U.S.                                    |                                |
|    | 13.   | FATHER'S NAME                             |   |                  |  |                    | MAIDEN NAME              |  |   | and .                          |
|    |   | Robert La                                 | shley                                       |                  |  | Do                 | reas Robin               | ette   |   |                                |
|    | 15.   | WAS DECEASED EVE                          | R IN U. S. ARMED FO                         | RCES? 16. S      | OCIAL SECURITY NO. 17. IN  | FORMANT            |                          | Address  | BEPER M.F. VALLE A SE                   |                                |
|    |   | No  |   |                  | 11   | iss. lia           | ry Lash                  | ley ht.  | Savage                                  | ,lid.                          |
|    |   | 18. CAUSE OF DEAT                         | Enter only one co                           | use par line fo  | The state of the s |                    |                          |  | TINTE                                   | ERVAL BETWEEN<br>SET AND DEATH |
|    |   |   |   |                  |  |                    |                          |  |   | udden                          |
|    |   | 24.0.0                                    | DUE 70                                      |                  | <u> </u>   |                    |                          |  |   |                                |
|    | Conditions, if ony, which) (b) Peptic Ulcer |   |   |                  |  |                    |                          |  | ?                                       |                                |
|    |   | gove rise to immedi                       | ofe couse                                   |                  |  |                    |                          |  | -                                       |                                |
|    |   | (a), stating the uncourse last.           | (c  |                  |  |                    |                          |  | 1                                       |                                |
|    | Z   | PART II. OTHE                             |   |                  | TRIBUTING TO DEATH BUT N   | OT RELATED TO      | THE TERMINAL DISEA       | SE CONDITION GIVE  | N IN PART I(o)                          | 19, WAS AUTOPSY                |
| j. | CATION                                      |   |   |                  |  |                    |                          |  |   | PERFORMED?                     |
|    | CERTIFIC                                    | 20a, EXTERNAL CAUS                        | SE WAS                                      | DE DESCRIBE      | HOW INJURY OCCURRED (EI  | Her noture of ir   | Lury in Fart I or Fort I | l of item 18.)   |   |                                |
|    | -   | CAUSE OF DEATH.                           | I KIBOTINGO LJ                              |                  |  |                    |                          |  |   |                                |
|    | MEDICAL                                     | 20c TIME OF INJUR                         | Month, Day, Ye                              |                  | HURY OCCURRED 20e. PLAC  | E OF INJURY (      | Home, form, 20f (Cit     | y or fawn)   | (County)                                | (State)                        |
|    | MED   | Hour o, m<br>p m,                         | 19  | While<br>of work | Not while O  | ry, situer, office | biographics              |  |   |                                |
|    |   | 21. I certify the                         | at I took charge                            | of the re        | emains described obov  | re, held on        | Autopsy 2, I             | nspection 🔼  | Inquiry X                               | , and in my                    |
|    |   | opinion death r                           | esulted from:                               | Natural ed       | ouses A. Accident  | 7. Suicid          | e 🔲, Homicide            | Undeter  | mined mann                              | er 🗍                           |
|    |   | 0   |   | 1 1/.            |  |                    | <u> </u>                 |  |   |                                |
|    |   | ACTUAL SIGNATURE                          | midich                                      | - X6,            | tarely/  | ALD CHIEF A        | MEDICAL EXAMINER         | )  |   | DATE SIGNED                    |
|    |   | J. C. |   | A STATES         | x = = = = = = = = = = = = = = = = = = =  | ASSISTA            | NT MEDICAL EXAMIN        | ER 🔲   |   |                                |
|    |   | EXAMINER'S NAME (Type) B                  | enedict                                     | Skita            | relic, M.D.  | DEPUTY             | MEDICAL EXAMINER         | May  | 22, 1                                   | 958                            |
|    | 220   | BURIAL CREMATION                          |   |                  | 20 NAME OF CEMETERY OR   | CREMATORY          | 22d LOC/                 | TION (City, fown, or   | county)                                 | (State)                        |
|    |   | REMOVAL (Specify)                         | May 25.                                     | 1958             | Methodist Cen  | netery             |                          | Savage.  | 27.4                                    |                                |
|    | 23.   | FUNERAL DIRECTOR'S                        |   |                  | ADDRESS  |                    | 24a. REC'D BY REGIS      |  | TRAR'S SIGNATU                          | ŊE.                            |
|    |   | Joseph H.                                 | Durst                                       | Frosth           | ourg, hd.  |                    | DATE MAY 2 6             | '50 (III)  | The education                           |                                |
|    |   |   |   |                  |  |                    |                          | The state of the s | 10 000000000000000000000000000000000000 |                                |



|  | 243  | CERTIFIC                    | AIE OF L                                   | DEATH                           |                        |                                      | Reg. Dis    | t. No.     |   |
|--|--|-----------------------------|--|---------------------------------|------------------------|--------------------------------------|-------------|------------|---|
| PLACE OF DEATH COUNTY Allegany   |  | MARYLANC                    |  | Md.                             | re deceased l          | ved. If instituted b. COUNTY         |             | e belore d |   |
| b. CITY OR TOWN (If outside of RIPA) and give necrest fown   | rporate limits, write                            | c. LENGTH OF STAY IN 18     | × Bart                                     |                                 | iside corporol         | le limits, write Al                  | JRAL ond g  | ive neares | I fown}                                   |
| d. NAME OF HOSPITAL (If not or institution trobe   | n haspitol, give street<br>St.                   | oddress)                    | / d street /<br>Latro                      |                                 |                        |                                      |             |            | IS RESIDENCE<br>ON A FARM?<br>(ES NOTE    |
| 3. NAME OF DECEASED (Type or print) John   | First  | Delzell                     | لم<br>Logsdon                              | şî                              | 4. DATE<br>OF<br>DEATH | May                                  | th          | Doy<br>9   | Yeor<br>1958                              |
| s. sex 6. colo<br>Male Whit  |  | RIED NEVER MARRIED DIVORCED | June 1                                     |                                 | 9                      | AGE (In years lost birthdoy) 58 yrs. |             |            | UNDER 24 HRS.                             |
| during most of working life, ex<br>ACCOUNTAIL  |  | S. Gov <sup>1</sup> t       |  | ton, M                          |                        | ntry)                                |             | ZEN OF     | WHAT COUNTRY                              |
| O. FATHER'S NAME William Logs  | lon  |                             | 14 MOTHER!                                 |                                 | AME<br>CGimps          | еу                                   |             |            |   |
| (Yes, no or unknown) (If yes, give in  | ARMED FORCES? 16.                                |                             | Mrs. John                                  | D. Lo                           | gsdon-                 | Addr<br>Barton,                      |             |            |   |
| Conditions, if any, which gove rise to immediate couse (a), stating the underlying couse lost.       | AUSED BY: TE CAUSE (o)  DUE TO  (b)  DUE TO  (c) | Corunary 1                  |  |                                 |                        |                                      |             | ONSET 13   | AL BETWEEN AND DEATH HOWYS                |
| PART II OTHER SIGNII  20a. ACCIDENT WAS UNDERL OR CONTRIBUTING II CAUSE U (IF EITHER, NOTIFY MEDICAL | VING 206 DES                                     | CONTRIBUTING TO DEATH E     |  |                                 |                        |                                      | EN IN PAKI  |            | PERFORMED?                                |
| 20c. TIME OF INJURY Month,<br>Hour o. m,<br>p. m.  |  | Not while_                  | PLACE OF INJURY<br>foctory, street, office | (Home, form,<br>te bldg., etc.) | 20f. (City o           | r town)                              | (C          | ounty)     | (Stote)                                   |
| 21. I certify that 1 pite alive on   | nded the decea<br>4 9 19                         | sed fram                    |  | 3:30/                           | 2M, fram               |                                      | ind an th   | e date     | the decease<br>stated above<br>DATE SIGNE |
| PHYSICIAN'S Pa   | UR. U  | 1,150m M.                   | D  |                                 |                        |                                      |             |            |   |
| REMOVAL ESECTIVI 5/  | 12/58  | Laurel Hi                   |  |                                 | Mos                    |                                      |             | Md.        | (State)                                   |
| 23. FUNERAL DIRECTOR'S SIGNATI   | //   | ADDRESS<br>Vesternport, A   | /id.                                       |                                 | BY REGISTRA            |                                      | STRAR'S SIG | 1          |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. may be retained by the haspital or attending physician.

TO FUNERAL DIRECTOR: A this mritical has limen signed by the attending physician and campletely filled in by the funeral page 3 shauld be detached for use as the burial-transit permit. Then please remove carbon paper? Pages 1 and 2 shauld be the registrar prior to burial, cremotian, ar removal, and in any event within 72 hours after death. VS A15 (4) 1\$M 9/5\$

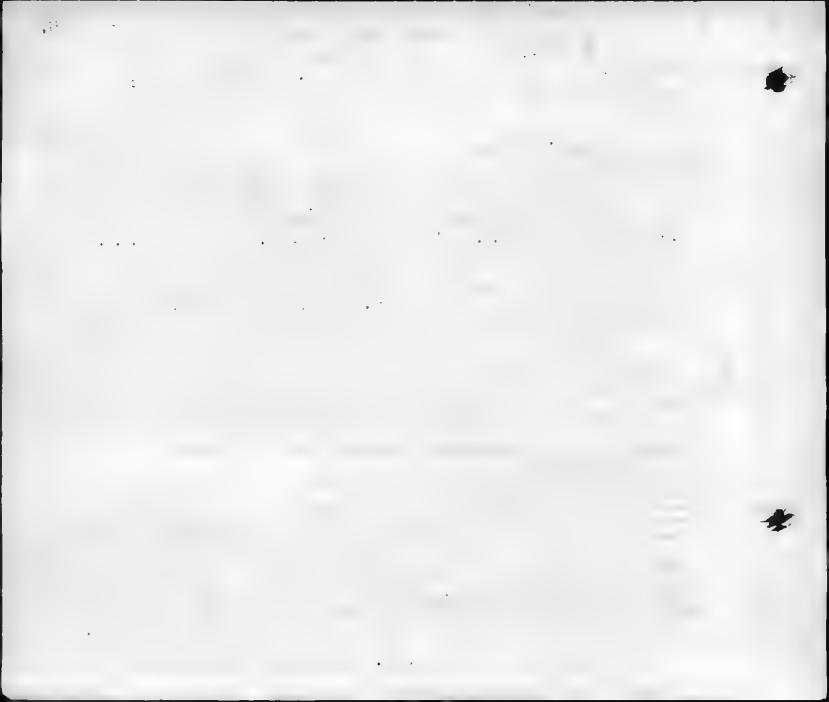
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Page 4



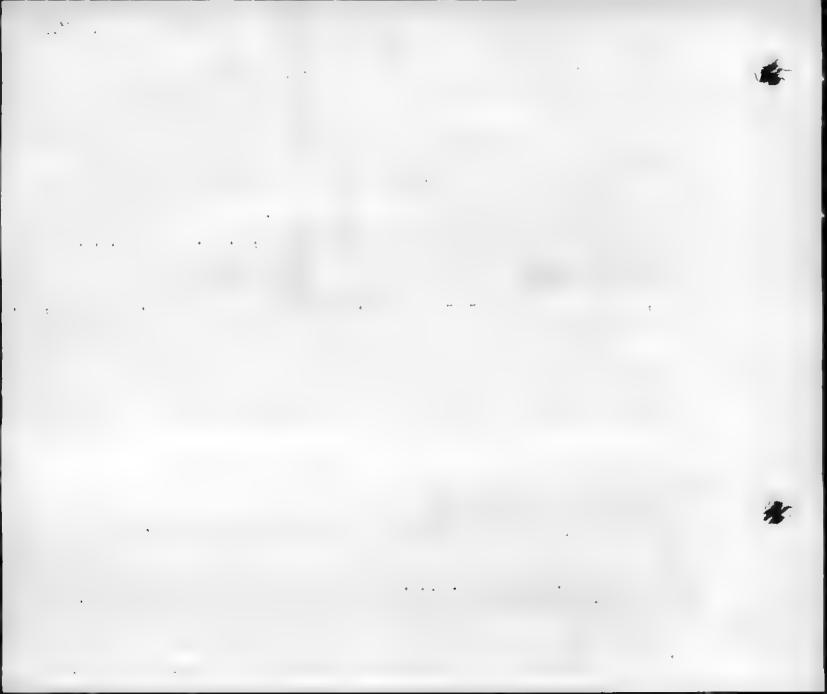
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(Stote)

24 haurs after deoth.

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VS A15 (4) 15M 10/57 H. Wayne George



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VS A15 (4)

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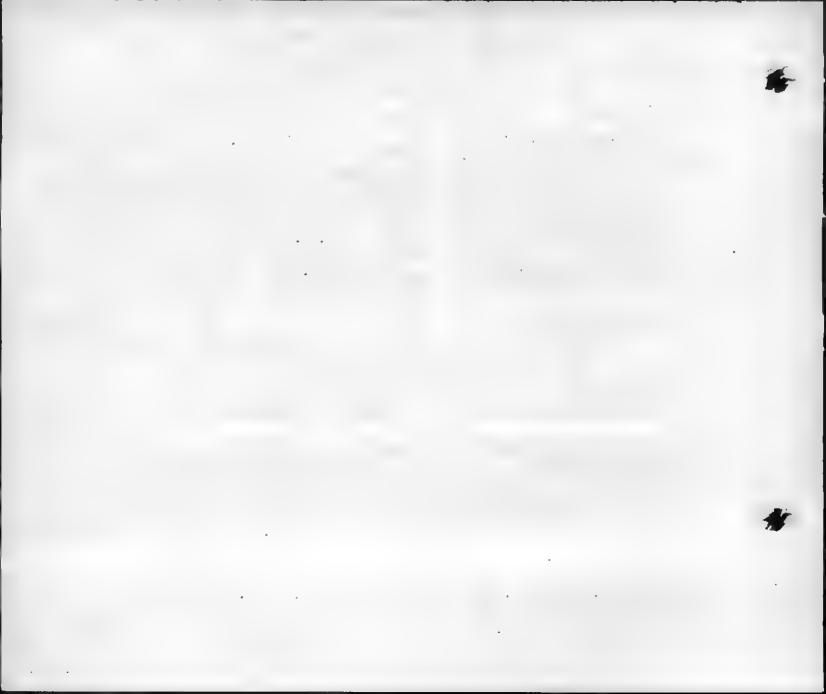
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CERTIFICATE OF DEATH Reg. Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. COUNTY 6 COUNTY Allegany MARYLAND Maryland b CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) hours Cumberland Cumberland d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENCE OR INSTITUTION ON A FARM? 200 Laing Ave. Lecred Heart Hospital YES NO NAME OF First Middle 4. DATE Month Day Yeor DECEASED 1958 McCusker (Type or print) Grace DEATH May 6. COLOR OR RACE 7 MARRIED NEVER MARRIED S. SEX 8. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS 9. AGE IIn years lost birthday) Months Doys Hours Min White Female WIDOWED [ DIVORCED | yrs. 10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (Slote or foreign country) 12 CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Housewife W.Va. 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME Samuel Friend (deceased Mary J. Ingla (decoazed) 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address Pt"s chart 18 CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c)." INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY-IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gave rise to immediate DUE TO cause (a), stoting the underlying cause lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(9) 19, WAS AUTOPSY PERFORMED? YES NO 200 ACCIDENT WAS UNDERLYING OF CONTRIBUTING CAUSE OF DEATH 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) Day, Year 20d INJURY OCCURRED (County) (State) factory, street, office bldg , etc.) a. m. While Not while at work at of work 1958 to They 6 1958 that I last saw the deceased 21. I certify that I attended the deceased from Thay and that death occurred at 3:50 m. from the couses and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE PHYSICIAN'S C.E.Durrett. Virginia Ave., Cumberland. NAME (Type) 22a. BURIAL, CREMATION, 22b. DATE THEREOF 22c NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, fown, or county) (Stote) REMOVAL (Specify) 1958 Davis Memorial Burn Park mol 23. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 24b. REGISTRAR'S SIGNATURE 24a. REC'D BY REGISTRAR

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TO õ ban physician Ö g. ğ 8. certificate has been si e as the burial-transit DIRECT O FUNERAL I O VS A15 (4) 1SM 10/S7

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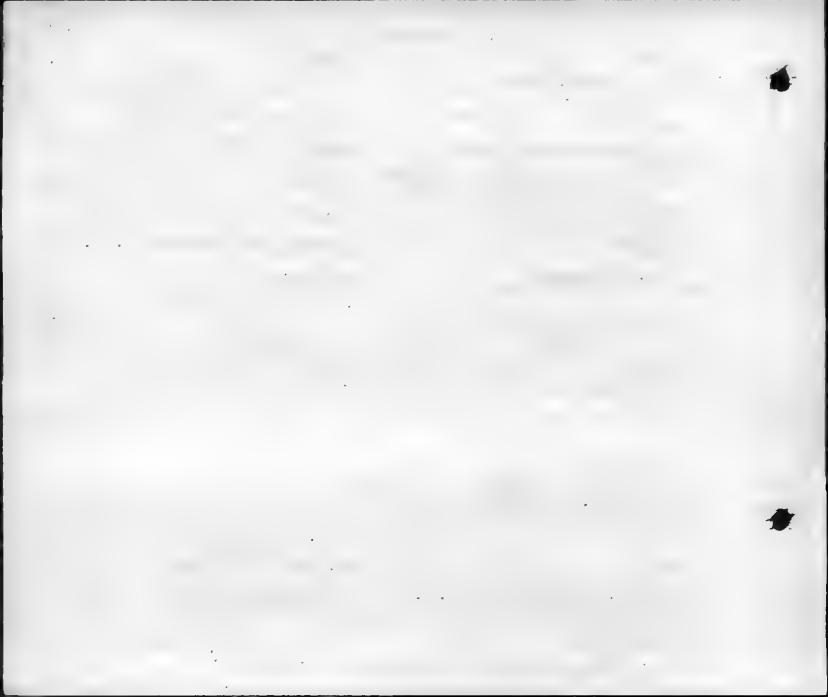
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: 4 this certificate has been signed by the attending physician and campletely filled in by the funeral page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be then with the registrar prior to burial cremation, ar remaral, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

|   |  |  | 20         | CERTIF                     | ICA      | IE OF DE                                  | AIH       |               |  | Reg. Di  | st. No.   |                   |                          |
|---|--|--|------------|----------------------------|----------|---|-----------|---------------|--|----------|-----------|-------------------|--------------------------|
|   | PLACE OF DEATH   | llegany Co   | unty       | MARYLA                     | - II     | 2. USUAL RESIDENCE<br>o. STATE<br>Marylar | CE (Whe   | ere deceased  | lived. If institution b. COUNTY ATTER    |          |           |                   | ion)                     |
| 1 | b CITY OR TOWN (If   | outside corporate limi                             |            | c. LENGTH OF STAY IN       | l 1b     |   |           | itside corpor | ole limits, write RL                     |          |           |                   | 1)                       |
| ı | RURAL and give ned   | rland  |            | oso years                  | 16       | Cumber                                    | land      | . Mar         | vl and                                   |          |           |                   |                          |
| ı | d. NAME OF HOSP,TA   |  | ive street | 4-4444                     |          | d. STREET ADDR                            |           | 614           | J. A.C.I.C.                              |          |           | e. IS RES         | DENCE                    |
| ı |  | 614 Bedfo  | rd 5.      | treet                      |          | Be Be                                     | edfo      | rd St         | reet                                     |          |           | YES [             | FARM?                    |
| Ì | 3. NAME OF<br>DECEASED   | Fir  |            | Middle                     |          | Last                                      |           | 4. DATE       | Mant                                     | h        | Doy       | y '               | Year                     |
| 1 | (Type or print)  | Ma   | TV         | Elizab                     | eth      | Mille                                     | ər        | OF<br>DEATH   | May                                      | r        | 13        |                   | 1958                     |
| ı | 5. SEX   | 6. COLOR OR RACE                                   | 7. MARR    | IED NEVER MARRIED          | □ 8.     | DATE OF BIRTH                             |           |               | 9. AGE (In years<br>last birthday)       | IF UNDER |           | IF UNDE           | ER 24 HRS.               |
|   | Female   | White  | WIDOWI     | DIVORCED                   |          | May 5, 18                                 | 373       |               | 85 yrs.                                  | Months   | Days      | Hours             | Min                      |
| I | 100 USUAL OCCUPATION   | N (Give kind at working life, even if retired      | dane 10b   | KIND OF BUSINESS OR        | INDUST   | RY 11. BIRTHPLACE                         | (State o  | or fareign ca | untry)                                   | 12. CIT  | IZEN O    | F WHAT            | COUNTRY?                 |
| ı | Housewif   |  | <u> </u>   |                            |          | Clarks                                    | burg      | . Wes         | t Virgini                                | ie i     | U.S.      | A.                |                          |
|   | 13. FATHER'S NAME  |  |            |                            |          | 14. MOTHER'S MA                           |           |               |  |          |           |                   |                          |
| ı | Rev. Jo  | seph Clark   |            |                            |          | Mary 1                                    | Rice      | . 1           | 614                                      |          |           |                   |                          |
| 1 | 15 WAS DECEASED EVER   | IN U. S. ARMED FOR                                 | CES? 16.   | SOCIAL SECURITY NO.        |          | ORMANT                                    |           |               | Addr                                     | ess      |           |                   |                          |
| 1 | No   |  |            | one                        | Mrs      | s. Alice N                                | McLu      | ickie,        | <del>我类类文</del> Bed                      | lford    | Şt.       | , Cu              | mber-                    |
| - |  |  |            | ne far (a), (b), and (c)-) | 4        | * ta                                      | , ,       |               |  |          |           | RVAL BE<br>ET AND |                          |
|   | PART 1. DEAT   | H WAS CAUSED BY: IMMEDIATE CAUSE (c                | )          | Termina                    |          | bronch                                    | rol       | no            | munder                                   | 9        |           | 2 des             |                          |
| 1 | 1 0  | DUE TO   | ) ];       | yportris                   |          |   |           | 1 7.          | · Cal.                                   | ^        |           | -                 |                          |
| 1 | Conditions, if an  |  |            |                            |          |   | n         | en            | e cour                                   | 7 ~      |           | 0 4               | ens                      |
| 1 | gave rise to im<br>catte (a), stating the  |  |            | vientos.                   |          |   |           |               |  |          | 2         | n 4.              | evra.                    |
| 1 | lying couse last.  | (  | 7          | catetas me                 |          |   |           |               |  |          |           |                   |                          |
|   | PART II. OTH   | er significant con                                 |            | CONTRIBUTING TO DEAT       |          | 4 45                                      |           |               |  |          | T 1(a) 19 | PERFO             | AUTOPSY<br>RMED?<br>NO 🏳 |
|   | PART II. OTHER PART III. OTHER | S UNDERLYING () ' CAUSE OF DEATH MEDICAL EXAMINER) | 20b. DES   | CRIBE HOW INJURY OCC       |          |   |           | ort 1 or Part | II of item 18.)                          |          |           |                   |                          |
|   |  | Month, Doy, Ye                                     | gr 20d, 1  | 7,                         | Oe. PLAC | E OF INJURY IHam                          | e. farm.  | 20f. (City    | or lown)                                 | fr       | Caunty)   |                   | (State)                  |
|   | Hour a.m.  |  | White      | Nat while                  | facto    | ry, street, office bld                    | g., etc.) |               | marked                                   |          | nd.       |                   | (0.0.0)                  |
| 1 |  |  |            |                            |          | CM-                                       | 17        | , , ,         |  |          |           |                   |                          |
|   |  | at I attended the                                  | deceas     | ed fram 184.               |          |   |           |               |  |          |           |                   |                          |
|   | alive an/_   | -11-4  | , 19       | =, and that d              | leath (  | accurred at 🕹 🕹                           |           |               | i fine causes a<br>reet, city or town, i |          | he dat    | e state           | d abave.                 |
|   | ACTUAL /   | 1. 00/21   | No         | 2 Olm                      |          | D. 122 Sc                                 |           | ,             | re Street                                |          | 1         | 4 2               | tion (3)                 |
|   | SIGNATURE/V  | 47170  | , ,        | 7                          | М.       | .D  | 300 011   | 00110.        | 20 00000                                 |          |           | 1 1/2             | 7.77                     |
|   |  |  |            | rmer, M. D.                |          | Cumber                                    | rlan      | d, Ma         | ryland                                   |          |           |                   |                          |
|   | 22a. BURIAL, CREMATION<br>REMOVAL (Specify)  |  |            | 22c. NAME OF CEMET         |          |   |           | -             | ION (City, tawn, a                       |          |           | (Stole            | e)                       |
|   | Burial   | May 15,  | 1958       | 1                          | t Bu     |   |           |               | berland,                                 |          |           | 3                 |                          |
| 1 | 23. FUNERAL DIRECTOR'S   |  |            | ADDRESS                    |          | 240                                       |           |               | RAR 245. REGIS                           |          |           |                   |                          |
|   | John J. Ha   | fer Cum  | berl       | and, Maryla                | and      | DA  | TE N      | 1AY 1 6       | '58 💢                                    | hed      | المماليين | ~                 |                          |



Reg. Dist. No.

2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) **b.** COUNTY Maryland Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) Cumberland d. STREET ADDRESS m. IS RESIDENCE ON A FARM? 118 Winton Place YES NO IN 4. DATE Manth Year 1058 Mitchell. DEATH 16th May IF UNDER 1 YEAR IF UNDER 24 HRS 8 DATE OF BIRTH 9. AGE (In years T4 yrs Months Days Jan. 13. 188L 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT COUNTRY? West Virginia U.S.A. MOTHER'S MAIDEN NAME William Mitchell Mary Joyce 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address Cumberland, Hd. Yes no or unknown) Miss. Margaret R. Mitchell 118 Winton Mace None 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c) ] INTERVAL BETWEEN 24 hours PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (g) Coronary Artery Occlusion 420.0 DUE TO Arteriosclerotic Heart Disease Conditions, if any, which vears gave rise to immediate DUE TO cause (a), stating the under-Arteriosclerosis, generalized years lying cause last PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED? Reactive Depression and poor nutrition secondary thereto YES TO NO PA 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) MEDICAL 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. [City or town). (County) (State) factory, street, office bldg., etc.) Hour a.m. While Not while at work at wark 1958, to May 16th, 19 58, that I last saw the deceased March 21. I certify that I attended the deceased from.\_\_\_\_ and that death accurred at 11 po M, from the causes and an the date stated above. glive on May 10th ADDRESS (Street, city or town, state) ACTUAL Algonquin Hotel SIGNATURE PHYSICIAN'S Wyand F. Doerner. Jr. M.D. Cumberland, Maryland, 22a. BURIAL, CREMATION, 22b. DATE THEREOF 22c NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State) Burial (Specify) S. S. Peter & Paul's Cem. Cumberland, Maryland 23 FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 24a. REC'D BY REGISTRAR 246~REGISTRAR'S SIGNATURE Cumberland, Maryland H. Wayne George DATE

certificate be physician attending permit. ificate has b may be retained by the F FUNERAL DIRECTOR: A page 3 shauld be detach o VS A15 (4) 15M 10/57

prior



HEALTH DEPT

PLACE OF DEATH e. COUNTY

NAME OF

5. SEX

DECEASED

(Type or print)

Male

13. FATHER'S NAME

Student

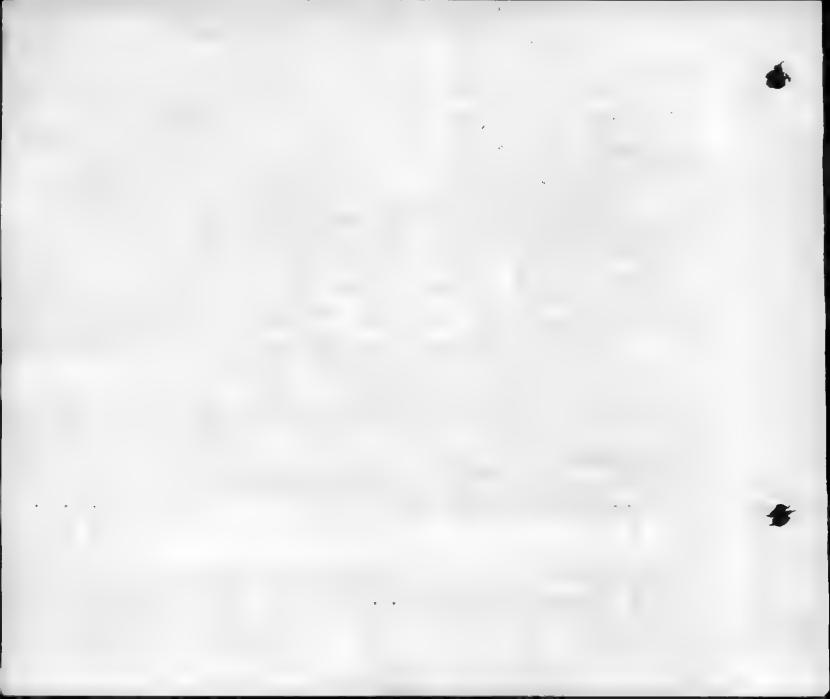
Boord of retained State death. moy be a with the 50 Poge ! in pencil in Item, 18. Give Poges 1, inner's Office along with form PM3. P o burial-tronsit permit. Puo removol. Exominer O Medical pinous F G

CTOR: orded DIREC FUNERAL E 0

VS A15ME 5M 2,57

### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) Virgin Pacounty Allegany West MARYLAND b. CITY OR TOWN (If outside corporate lim to, write RURA) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate I mits, write RURAL and give nearest town) Few Hours Cumberland Ridgelev. W. Va d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARMP Memorial Hospital YES 110 3 Middle 4. DATE Month Doy DEATH 1958 May Ronald Morris THUNDER TYEKE 6 COLOR OR RACE 7. MARRIED NEVER MARRIED X . B. DATE OF BIRTH 9 AGE (In years IF UNDER 24 HRS fort birthday) Months Doys Hours Min. DIVORCED [ White WIDOWED [ 100, USUAL OCCUPATION (G ve kind of work done 10b KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or fareign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Independence W. Va. High School USA 14. MOTHER'S MAIDEN NAME Georgia E. Cordi 16. SOCIAL SECURITY NO. 17. INFORMANT Mr. Samuel Morris, Ridgeley, W. Va. INTERVAL BETWEEN ONSET AND DEATH

Samuel Morris 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 18 CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c) PART I, DEATH WAS CAUSED BY: Fractured Skull and Neck Sudden IMMEDIATE CAUSE (c) DUE TO Conditions, if any, which gove rise to immediate couse DUE 10 (a), stoting the underlying couse last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES [ NO DC 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Part It of item 18.) 20o. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING Automobile Accident 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, #20f. (City or town) Month, Doy, Year 20c. TIME OF INJURY (County) factory, street, office bldg., etc.) Ridgely Mineral. Street at work of work 21. I certify that I took charge of the remains described above, held an Autapsy , Inspection A. Inquiry . Accident 2, Suicide . opinion death resulted from: Natural causes Homicide . Undetermined manner DATE SIGNED ACTUAL CHIEF MEDICAL EXAMINER SIGNATURE ASSISTANT MEDICAL EXAMINER **EXAMINER'S** Benedict Skitarelic. M.D. DEPUTY MEDICAL EXAMINER IN NAME (Type) 220. BURIAL CREMATION, 226 DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d EOCATION (City, town, or county) (Stote) Fort Ashby Cemetery 7.1958 Fort 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24n REC'D BY REGISTRAR 246. REGISTRAR'S SIGNATURE James F. Scarpelli, Cumberland, Md. DATMAY 6 '58



VS A15ME 8M 2/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 52MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05209

|   |   | Reg, Dist. No.   |
|---|---|--|
|   | 1. PLACE OF DEATH  o. COUNTY  MARYLAND  | 2 USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o STATE by County   |
|   | b. CITY OR TOWN (the outside course to limits, we altura, c. LENGTH OF STAY IN 16 and give negret tous)   | c CITY OR TOWN (If puts de carparete limits, write RURAL and gurghearest town)   |
|   | d. NAME OF HOSPITAL OR INSTITUTION (IF not in hospital, give preet oddress)   | d. STREET ADDRESS  226 Carroll St YES NO ID  |
|   | 3. NAME OF First Middle DECEASED (Type or print) Lillevic Bell Myer   | Losi 4. DATE Month Doy Year Of   |
|   | 5. SEX  6. COLOR OR RACE   MARRIED   NEVER MARRIED   I VORCED   | 3. DATE OF BIRTH 9. AGE (In yours   IFUNDER TYEAR IF UNDER 24 Ites   |
| 1 | 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUS during most of working life, even firetired)   |  |
|   | 13. FATHER'S NAME   | 14. MOTHER'S MAIDEN NAME   |
|   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17.  | NFORMANT Dalla Address Carolo M. &   |
|   | 18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c) ]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE [o] Arteriosclerot:  DUE TO  Conditions, If only, which gove rise to immediate cause (a), stoling the underlying cause lost.  (c) |  |
|   | 200   | NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19, WAS AUTOPSY PERFORMED.  YES NOTE THE PART I or Part I or Part II of Item 18 ) |
|   | 3 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e PLA   | CE OF INJURY (Home, farm, 20f. (City or town) (County) (5101e) ory, street, office bldg., etc.)  |
|   | 21. I certify that I took charge of the remains described about opinion death resulted from: Natural causes X. Accident   | 7  |
|   | ACTUAL Benedict Sketarilia  | M_D CHIEF MEDICAL EXAMINER   |
|   | EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.  220 SUBJAL CREMATION, 27b. DATE THEREOF, 27c. NAME OF CEMETERY OF   | DEPUTY MEDICAL EXAMINER MAY 23, 1958  CREMATORY   72d LOCATION (City, town, or county) (Stote)   |
|   | 23 FUNEAL DIRECTOR'S SIGNATURE ADDRESS ACCEPTED   | 240. REC'D BY MEGISTRAR 240, REGISTRAN'S SIGNATURE  MAY 2 6 '58 000 000 0000   |



., 52



VS A15 (4) 15M 10/57

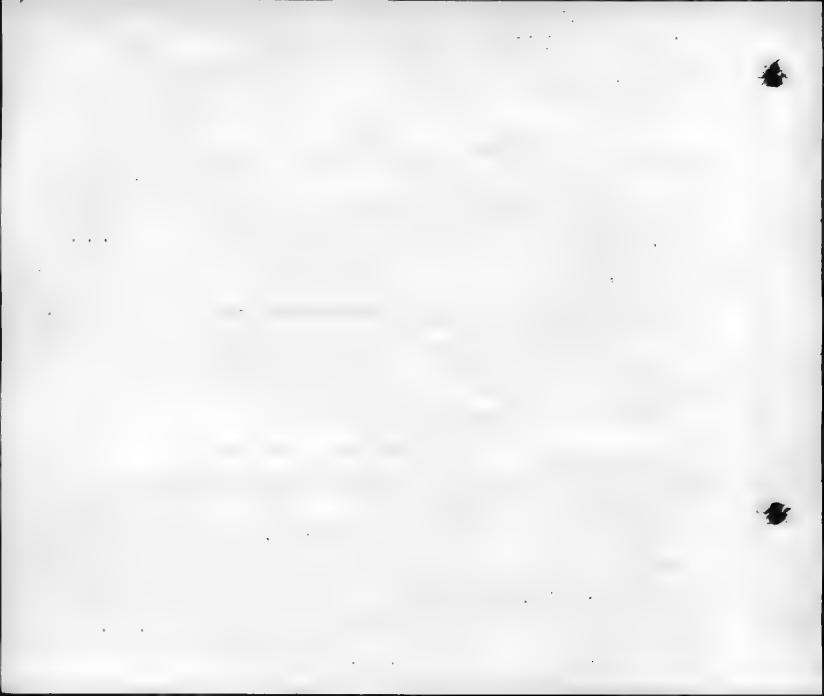
DR. DURRETT

# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CEPTIFICATE OF DEATH

05211

|   | 114  | 110  |                    |  |                         |                        |                                 | Reg. Dis     | l. No.               |                      |
|---|--|--|--------------------|--|-------------------------|------------------------|---------------------------------|--------------|----------------------|----------------------|
| PLACE OF DEATH                                    | LEGANY   | MA   | RYLAND             | 2. USUAL RESIDEN                           | IRGI                    | NIA                    | ived. If instituti<br>b. COUNTY |              | e before odn         | nusion)              |
| RURAL and give n                                  | If outside corporate limits, writed earest town)             |  | Y IN 16            | c. CITY OR TOV                             | MN (If ou               | tside corpora          | te limits, write R              | URAL ond g   | ve nearest to        | own)                 |
| COMBERI   | LAND   | 9 DAYS   |                    | WILEY                                      |                         | D                      | 5.                              |              |                      |                      |
| OR INSTITUTION                                    | TAL (If not in hospitol, give st<br>EMORIAL HOSPI)           | TAL  |                    | d. STREET ADD                              | RESS                    |                        |                                 |              | 10                   | RESIDENCE<br>A FARM? |
| 3. NAME OF<br>DECEASED<br>(Type or print)         | WILLIAM  | TAY  | LOR                | O BRI                                      |                         | 4. DATE<br>OF<br>DEATH | MAY                             |              | Day                  | 19 58                |
| S SEX   | 6 COLOR OR RACE 7. A   | MARRIED NEVER MAR                                | RIED 🗍 8           | DATE OF BIRTH                              |                         | 9.                     | AGE (In years                   | IF UNDER 1   |                      | IDER 24 HRS.         |
| MALE  | 7.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1                      | DIVOR  | -                  | JUNE 9                                     |                         |                        | lost birthdoy)                  | Months       | Days Hau             | rs Min.              |
| 100. USUAL OCCUPATION during most of wor Ret. Far | ON (Give kind of work dane king life, even if retired) "MCI" | 106. KIND OF BUSINESS Farmin                     |                    | RY 11. BIRTHPLACE WEST                     | E (Stole o              | GINIA                  | ntry)                           | 12. CITI     | U.S.A                | AT COUNTRY           |
| 13. FATHER'S NAME                                 |  |  |                    | 14 MOTHER'S MA                             | AIDEN NA                | <b>LME</b>             | -                               |              |                      |                      |
| JOHN O  | BRIEN  |  |                    | MARY LI                                    | KINS                    |                        |                                 |              |                      |                      |
| (Yes, no. or unknown)                             | R IN U. S. ARMED FORCES?                                     | 16. SOCIAL SECURITY N                            | 0 17. IN           | FORMANT                                    |                         |                        | Add                             | ress         |                      |                      |
| No  |  | None   | M                  | EMORIAL H                                  | IOSPI                   | TAL-ME                 | MORIAL                          | & WARW       | ICK A                | VES.                 |
|   | ATH [Enter only one couse po<br>ATH WAS CAUSED BY            | er line for (o), (b), and (o                     | lea                | enie                                       |                         |                        |                                 |              | INTERVAL<br>ONSET AN |                      |
| 4221  | DUE TO   |  |                    |  |                         |                        |                                 |              | 2                    | 162                  |
| Conditions, if o                                  | -  | Murena   | ites.              | . 51                                       | Sec                     | 0                      | leves                           | 1            | -                    | c W                  |
| gove rise to i                                    | mmediate (   |  |                    | 3  |                         |                        |                                 | -201         | -5                   | 200                  |
| Lying couse lost,                                 | the under-   | Chrite   | Ther               | scle                                       | سمسار                   | ens                    |                                 |              | 13                   | 5-12                 |
| PART II. OTH                                      | HER SIGNIFICANT CONDITIO                                     | NS CONTRIBUTING TO D                             | EATH BUT N         | OT RELATED TO TH                           | E TERMIN                | AL DISEASE C           | ONDITION GIV                    | EN IN PART   | 1(o) 19. WA          | S AUTOPSY<br>FORMED? |
| 3   |  | ***  |                    |  |                         |                        |                                 |              |                      | NO D                 |
| O THE EITHER, NOTIFE                              | AS UNDERLYING (1) 206. CAUSE OF DEATH MEDICAL EXAMINER)      | DESCRIBE HOW INJURY                              | OCCUR <b>red</b> . | (Enler nature of in                        | jury in Pa              | et f or Part ()        | of item 18.)                    |              |                      |                      |
| 20c. TIME OF INJUR<br>Hour a. m.<br>p. m.         | - W  | Od. INJURY OCCURRED Thile Not while work of work | 20e. PLAC          | CE OF INJURY (Honory, street, office bloom | ne, form,<br>dg., elc.] | 20f (City of           | r lown)                         | (Co          | ounty)               | (Stote)              |
| 21. I certify th                                  | at I attended the dec  | eased from 2                                     | 7 5                | 1950                                       | 677                     | day,                   | 13, 195                         | Bihat I le   | ast saw th           | a docean             |
| alive an  | tay 17   |  |                    | accurred at2:                              | 35 A                    | M. from                | the couses o                    | and an the   | a data et            | ated above           |
|   | 0  | /  |                    |  | Al                      | DDRESS (Street         | N, city or town,                | stote)       | e didle sit          | DATE SIGNES          |
| SIGNATURE C                                       | earl &   | surret   | M                  | 0236                                       | Da                      | -less                  | Eum                             | Luch         | 25                   | 7/3/5                |
| PHYSICIAN'S<br>NAME (Type)                        | DR. CLAY E. D  | URRETT   |                    |  |                         |                        | *********                       |              |                      |                      |
| 220 BURIAL CREMATIO<br>REMOVAL Specify)<br>BUP181 | iay 15,195   | 72c. NAME OF CE                                  |                    |  |                         | An                     | tioch,                          | Vr . V       | a. (Si               | lote)                |
| 23. FUNERAL DIRECTOR                              | 'S SIGNATURE   | ADDRESS<br>Cumberla                              |                    | 1 d 24                                     | o. REC'D                | BY REGISTRA            | R 24b REGIS                     | STRAR'S SIGN |                      |                      |
|   |  |  |                    | U/   | 716                     |                        |                                 | a show       | W.                   |                      |



Rea. Dist. No

| PLACE OF DEATH  | GANY                                   | MARYLAND                             | 2. USUAL RESIDENCE (W<br>0. STATE<br>MARYLAND | here deceased lived If institution b. COUNTY | Residence before admission)                           |
|---|--|--------------------------------------|---|--|---|
| RURAL and give  |  | c. LENGTH OF STAY IN 15              | 1 1 7   | outside corporate limits, write RU           | IRAL and give nearest town)                           |
| d NAME OF HOS<br>OR INSTITUTIO                          | PTAL (If not in hospital, give street  |                                      | d. STREET ADDRESS                             | LAND   | e IS RESIDENCE<br>ON A FARM?                          |
| MEMORIA   | L HOSPITAL, MEMO                       | DRIAL AVE.                           | 320 PENN.                                     | AVE.   | YEX NO  |
| 3. NAME OF<br>DECEASED<br>(Type or print)               | MR. WALT                               | Middle  No PARSO                     | Lost<br>DNS                                   | 4. DATE Month OF DEATH MAY                   | Doy Yeor<br>25 19 58                                  |
| MALE.   | 6. COLOR OR RACE 7 MAR                 | RIED NEVER MARRIED DIVORCED DIVORCED | 8 8/7 /1894                                   | last birthday)                               | Months Days Hours Min                                 |
| OG USUAL OCCUPA   | TION (Give kind of work done) 10b      | KIND OF BUSINESS OR INDU             |   |  | 12. CITIZEN OF WHAT COUNTRY                           |
| Carpen  | forking life, even if relifed)         | वयाय प्राचित्र                       | O. R. R.                                      | WEST VIRGIN                                  |   |
| 3. FATHER'S NAME ELWOOD                                 | PARSONS                                |                                      | 14 MOTHER'S MAIDEN I                          | SHANNON                                      |   |
| S WAS DECEASED E  | VER IN U. S. ARMED FORCES? 16          | SOCIAL SECURITY NO 17                | INFORMANT                                     | Addre  | 133   |
| NO NO   | [If yes, give war or dates of service] | 5-05-1780 MEM                        | ORIAL HOSPITA                                 | L, CUMBERLAND,                               | MD.   |
|   | EATH [Enler only one couse per I       | ine far (a), (b), and (c).]          |   |  | INTERVAL BETWEEN<br>ONSET AND DEATH                   |
| 1/00  | IMMEDIATE CAUSE (6)                    | I (Ironice -                         | ····  |  | 7 day   |
| Conditions, if  | ony, which ) a(b)                      | Execusion to C                       | July Banch                                    | Assense                                      | 14 Minute   |
| gave rise to<br>cause (a), statin                       | immediate and the under-               | B. J.+                               | Pl (  | D1 41  | 101000  |
| Lying cause los   | 1 101-4                                | 1) mullectual                        | 2 - CALUNCE                                   | rumay to hear                                | ls  |
| D PAH II C  | OTHER SIGNIFICANT CONDITIONS           | CONTRIBUTING TO DEATH BUT            | T NOT RELATED TO THE TERM                     | INAL DISEASE CONDITION GIVE                  | N IN PART 1(a) 19 WAS AUTOPSY<br>PERFORMED?<br>YES NO |
| 20a. ACCIDENT V<br>OR CONTRIBUTION<br>(IF EITHER, NOTIL | WAS UNDERLYING (1) 20b. DES            | SCRIBE HOW INJURY OCCURRE            | ED (Enter noture of injury in                 | Part I or Part II of item 18.)               |   |
| 20c. TIME OF INJ  |  |                                      | ACE OF INJURY (Home, form                     | n, 20f. (City or town)                       | (County) (Slote)                                      |
| Hour o.m  | 16                                     |                                      | ctary, street, affice bldg., etc              | 5.)  |   |
| 21. I certify   | that I offended the decea              | sed from luly                        | , 19 <u>5</u> 4, 10                           | May 1958                                     | ,that I lost sow the deceose                          |
| olive on  | May 25 12.                             | one that death                       | occurred of 1:45F                             |  | nd an the date stated above                           |
| ACTUAL<br>SIGNATURE                                     | Stoleumela                             | yes the                              | м.р. 13300                                    | ADDRESS (Street, city or town, st            | and M& 5/26/5   |
| PHYSICIAN'S<br>NAME (Type)(                             | G. O. Himne                            | Whight, Mi                           | 0   |  |   |
| REMOVAL (Specif   | ION, 726. DATE THEREOF                 | 27c NAME OF CEMETERY O               | P. Coll Com                                   | 22d. LOCATION (City, town, or                | county) (Slate)                                       |
| 3. FUNERAL DIRECTO                                      | DR'S SIGNATURE                         | DDRESS                               | 240. REC'                                     | D BY REGISTRAR / 256 REGIST                  | IRAR'S SIGNATURE                                      |
| UHAZ  | ecas NX                                | NA 9Ken                              |   | MAY 2 8 '58   Que                            | 1 -0  |

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18



WINE TO



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### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5211

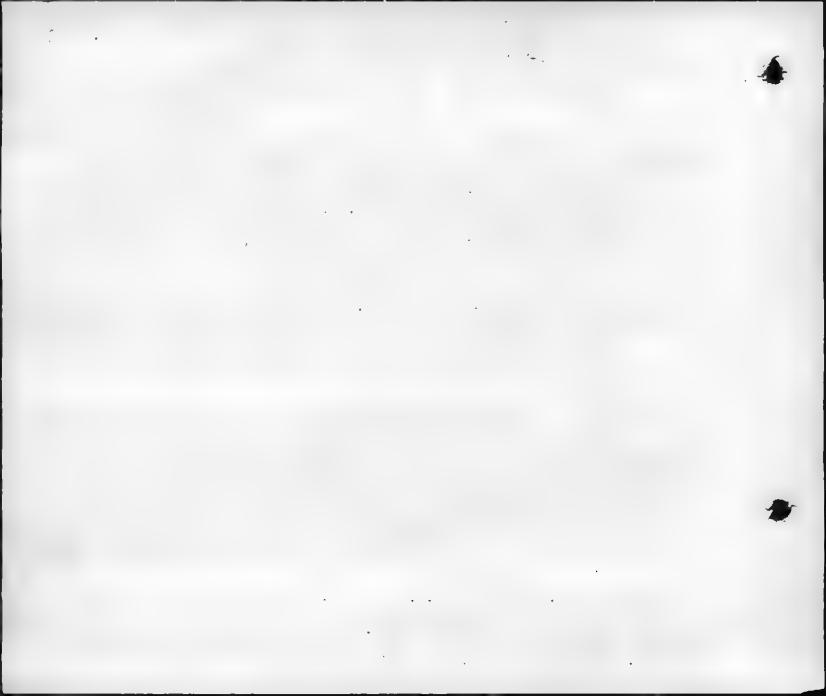
## **CERTIFICATE OF DEATH**

05214

Rea. Dist. No.

| ъ. |  |  |              |                               |                  |   |                           |                        |                                 |                |                |                     |
|----|--|--|--------------|-------------------------------|------------------|---|---------------------------|------------------------|---------------------------------|----------------|----------------|---------------------|
| )  | 1 PLACE OF DEATH<br>0 COUNTY                       | allegary   | ad           | MARY                          | LAND             | 2 USUAL RESIDE<br>a. STATE                | NCE (Whe                  |                        | l lived. If instits<br>b. COUNT | TY             | e before admi  | ssion}              |
|    | b. CITY OR TOWN<br>RURAL and give                  | (If outside corporate limi   |              | LENGTH OF STAY                | IN 1b            |   |                           |                        | rote limits, write              | RURAL ond g    | ive nearest to | vn) ~               |
| 3  | Cumberla<br>d NAME OF HOSP<br>OR INSTITUTION       | nd<br>ITAL (If not in hospital, g                                  |              | years<br>Bress)               |                  | d. STREET ADD                             | DRESS                     | erlan                  | d<br>avement                    | ,              | ON             | ES DENCE<br>A FARM? |
|    | 3. NAME OF   | Fin<br>THOMAS  | st           | Middle GUY                    | REF              | Lost                                      | 1                         | 4. DATE<br>OF<br>DEATH | May 1                           | on th          | Day            | Yeor<br>10 58       |
|    | s. sex<br>Male                                     | 6. COLOR OR RACE White   | 7 MARRIED    |                               |                  | ct. 7,                                    | 1887                      |                        | 9. AGE (In year                 | Months         | YEAR IF UNI    | DER 24 HRS          |
|    | 100. USUAL OCCUPAT<br>during most of wo<br>Retired | ON (Give kind of work or<br>rking life, even if retired            |              | O Railr                       |                  |   |                           |                        | West Vi                         |                | ZEN OF WHA     | T COUNTRY           |
|    | 13. FATHER'S NAME                                  |  | 3            |                               |                  | 14 MOTHER'S M                             | AIDEN NA                  | AME                    |                                 |                |                | -                   |
|    | NO WAS DECEASED BY                                 | Edwin Ree  |              | CIAL SECURITY NO              | 17 16            | Allie                                     |                           | - I                    |                                 |                |                |                     |
|    | Yes no. at unknown)                                | WW 1   | 705          | 5-07-2269                     | Mı               | s. Harry                                  | y Hag                     | E () 30                | 28 Quee<br>Cumberl              |                |                |                     |
|    | PART I, DE   | ATH [Enter only one co<br>ATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (o | -2-32        | your                          | rel              | tir                                       |                           |                        |                                 |                | INTERVAL E     |                     |
|    | Conditions, if                                     |  | Bu           | nch                           | مد               | time                                      | ą.                        |                        |                                 |                | 4-4            | er-                 |
|    | gove rise to couse (a), stating lying couse last   | the under- DUE TO  | 1            |                               |                  |   |                           |                        |                                 |                |                |                     |
| ر  | PAIR II. OT  | HER SIGNIFICANT CON  | DITIONS CON  | NTRIBUTING TO DEA             | ATH BUT I        | NOT RELATED TO TI                         | HE TERMIN                 | IAL DISEASI            | E CONDITION G                   | IVEN IN PART   | PERF           | AUTOPSY<br>ORMED?   |
|    |  | AS UNDERLYING  G CAUSE OF DEATH MEDICAL EXAMINER)                  | 20ь. DESCRII | BE HOW INJURY OF              | CCURRED          | (Enter noture of i                        | njury in Po               | ort I or Port          | li of dem 16)                   |                |                |                     |
|    | ZOc. TIME OF INJU<br>Hour o. m.<br>p. m            | RY Month, Doy, Yeo   | While _      | RY OCCURRED Not while of work | 20e. PLA<br>foct | CE OF INJURY (Ho<br>ory, street, office b | me, form,<br>ildg., etc.) | 20f (City              | or town)                        | (C             | ounty)         | (Stote)             |
|    | 21. I certify t                                    | hat I attended the   | deceased     | J //                          |                  |   |                           |                        |                                 |                |                |                     |
|    | ACTUAL   | 20 8   | Ĺ            | e,-, and that                 |                  | accurred at                               | A                         | DDRESS (St             | reet, city or tow               | n, stote]      | e date stat    | ed abave            |
| 1  | SIGNATURE  | elayt.   | On w         | view                          | h                | 1.0 476 46                                | a, a                      | 12                     |                                 |                | 4              | 3/3                 |
| 1  | PHYSICIAN'S<br>NAME (Type)                         | Clay E. D  |              | M.D.                          |                  | 236 Va.                                   | Aveni                     | ue, E                  | umberla                         | ind, Ma        | arylan         | d                   |
|    | 220. BURIAL CREMATION REMOVAL (Specify Burial      |  |              | 2c NAME OF CEME<br>\rlingtor  |                  |   | ery                       | 22d. 10CAT             | lingtor                         | or county)     | ginia          | ite)                |
|    | 23. FUNERAL DIRECTO                                |  |              | ADDRESS                       |                  | 2-  |                           | BY REGIST              |                                 | GISTRÁR'S SIGI |                |                     |
|    | JOHN J.  | naier. cum   | nerran       | acr. Pictrv l                 | Land             |   | MA                        | 11                     | 20 1 7 1                        | 17-12- 2 AL    | JULY N         |                     |

YS A1S (4) 1SM 10/S7



VS A15 (4) 15M 10/57

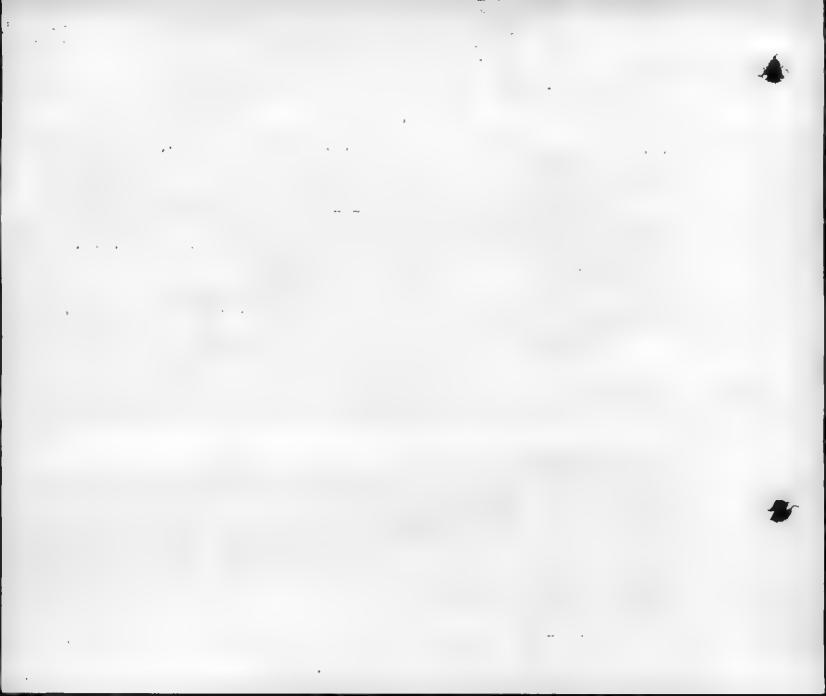
PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **CERTIFICATE OF DEATH** 

05215

Reg. Dist. No.

| 1 | 1.      | PLACE OF DEATH<br>COUNTY              |                            |             |                        |           | 2 USUAL RESI         | DENCE (WI      | here deceased  | lived If institut         |               | before adm    | ission)              |
|---|---------|---------------------------------------|----------------------------|-------------|------------------------|-----------|----------------------|----------------|----------------|---------------------------|---------------|---------------|----------------------|
| ] |         |                                       | egany                      |             | MA                     | RYLAND    | 7. 6                 | arvl           | and            | b. COUNTY                 | Alleg         | าดทาง         |                      |
|   |         | b CITY OR TOWN (If RURAL and give new | outside corporate lim      | ils, write  | c LENGTH OF STA        | AY IN 1b  | c CITY OR            | TOWN (IF       | outside corpo  | rote limits, write I      | RURAL ond giv | ve nearest to | w(n)                 |
|   |         | Eckhart                               |                            |             | 28 yr                  | S.        | X                    | lckha          | rt             |                           |               |               |                      |
| 2 |         | OR INSTITUTION                        | LL (If not in hospital, g  | give street | oddress)               |           | d. STREET            | ADDRESS        |                |                           |               | e. IS R       | ESIDENCE             |
| , | L       | R.D. #3                               | Frostbur                   | ō.          |                        |           | 'R.D.                | #3,F           | rost           | ourg, Md                  | •             |               | A FARM?              |
|   | 3.      | NAME OF<br>DECEASED                   | Fie                        | rst         | Midd                   | lle       | La                   | st             | 4. DATE        | Мо                        | ath           | Day           | Year                 |
|   |         | (Type or print)                       | ULIA                       |             | M                      | . RI      | EPHANN               |                | OF<br>DEATH    | 5                         |               | 19            | 1958.                |
|   | 5. 5    |                                       | 6. COLOR OR RACE           | 7 MARE      | RIED NEVER MAR         | RIED 🔲    | B DATE OF BIRT       | Н              |                | 9. AGE (In years          | IF UNDER 1    | YEAR IF UN    |                      |
|   |         | F                                     | W                          | WIDOW       | ED DIVOR               | CED 🔲     | 9-5-18               | 393            |                | lost birthday)<br>64 yrs. | Months D      | Days Hou      | s Min.               |
|   | 10a     | . USUAL OCCUPATIO                     | N (Give kind of work       | done 10b.   | KIND OF BUSINESS       | OR INDUS  | TRY 11 BIRTHP        | LACE (Stote    | or foreign co  | ountry)                   | 12. CITIZ     | EN OF WH      | AT COUNTRY           |
|   |         | Housewor                              | ng life, even if retired   | '   (       | wn Home                |           | Frie                 | ndsv           | ille.          | Tra -                     | II            | S.A.          |                      |
|   | 13.     | FATHER'S NAME                         |                            |             | 1111 110110            |           | 14. MOTHER'S         |                |                | 374.02                    | 1.0           | 0 0 1 12 1    |                      |
|   |         | Harvey H                              | leilman                    |             |                        |           |                      | e No           | -              |                           |               |               |                      |
| _ | 15.     | WAS DECEASED EVER                     |                            |             | SOCIAL SECURITY N      | 10 17. H  | NFORMANT             |                | Box            | 87 Add                    | Iress         |               |                      |
|   |         | I (I                                  | yes, give —or or date of s | ervice)     | None                   | Vic       | ctor Re              | phan           |                | .3,Fro                    | stbur         | g, Md         |                      |
|   |         | IB CAUSE OF DEAT                      | TH [Enter only one co      | ouse per hi | ne for (o), (b), ond ( | 910       | . 1 /                | `              |                |                           |               | INTERVAL      | BETWEEN              |
|   |         |                                       | H WAS CAUSED BY:           |             | enera                  | Vise      | 201                  | 61201          | n.An           | 20/0-                     | / -           | ONSET AN      | D DEATH              |
|   |         | 170x                                  | IMMEDIATE CAUSE (c         |             |                        | Juge      | 4                    | 0000           | -              | su (No                    |               | and .         | 114                  |
|   |         |                                       |                            |             | 102110                 | n dim     | 3-                   | 111            | 8000           |                           |               | 111           | 1001.                |
|   |         | Conditions, if an gave rise to im     | mediote                    | 4.00        | COUNT                  | VVI       | ria                  | 00             | In ROL         | <u> </u>                  |               | 47            | mary                 |
|   |         | couse (a), stating th                 |                            |             |                        |           |                      |                |                |                           |               |               |                      |
|   | _       | lying couse lost.                     | ) (c                       | )           |                        |           |                      |                |                |                           |               |               |                      |
|   | CATION  | PART II. OTHI                         | ER SIGNIFICANT CON         | DITIONS     | CONTRIBUTING TO        | DEATH BUT | NOT RELATED TO       | THETERMI       | NAL DISEASI    | CONDITION GI              | VEN IN PART   | (a) 19. WA    | S AUTOPSY<br>FORMED? |
| 3 | 14      |                                       |                            |             |                        |           |                      |                |                |                           |               |               | NO D                 |
|   | 買       | 20g. ACCIDENT WAS                     | UNDERLYING [               | 20b. DES    | CRIBE HOW INJURY       | OCCURRED  | ). (Enter noture o   | of injury in I | Port I or Part | It of item 18.)           |               |               | -                    |
|   | CERTIF  | (IF EITHER, NOTIFY A                  | MEDICAL EXAMINER)          |             |                        |           |                      |                |                |                           |               |               |                      |
|   | 3       | 20c. TIME OF INJURY                   | Month, Day, Yes            | or 20d II   | NJURY OCCURRED         | 20e PLA   | CE OF INJURY         | Home form      | 20£ (City      | os town)                  | 100           | uniyi         | 450-4-3              |
|   | MEDICAL | Hour a.m.                             | 19                         | While       | Not while              | foc       | tory, street, office | e bldg., etc.  | )              | Ot Igwiij                 | ICO           | uniyi         | (Stole)              |
|   | ×       | p. m.                                 |                            | of wor      | k at work              | 17        |                      |                | -              |                           |               |               |                      |
|   |         | 21. I certify the                     | at I attended the          | decease     | ed fram I-l            | K-/-      | ع كيو1 ,             | 2. to_ Z       | 204-1          | 19.56                     | 5,that I la   | st saw th     | e decease            |
|   |         | alive an                              | d4 16                      | 19.2        | 2 and the              | at death  | occurred at          | 033%           | LM. from       | the causes                | and an the    | date sta      | ited abov            |
|   |         |                                       | 1.0-mx                     | 1           |                        |           | 1                    | 12.4.2         | ADDRESS (SA    | reet, city or town,       | stote)        |               | DATE SIGNE           |
|   |         | ACTUAL<br>SIGNATURE                   | 141711C                    | 1           | ans                    |           |                      | Fra            | - AR           | 111 m                     | 1 -           | MI.           | 20 110               |
| 1 |         | SIGNATURE                             |                            | N           |                        |           | M.D                  | bf-lls         | 4-4-0          | ng_111                    | g/-           | frag.         | V198                 |
| I |         | PHYSICIAN'S<br>NAME (Type)            | vom                        | 4           | ane                    |           |                      |                |                | / '                       |               |               | ·                    |
|   | 220     | BURIAL, CREMATION                     | , 22b. DATE THEREO         | F           | 22c. NAME OF CE        | METERY OF | CREMATORY            |                | 22d LOCAT      | ION (City, fown,          | or county)    | r5t           | ofe)                 |
|   | )       | REMOYAL (Specify)                     | 5-21-58                    |             | Eckhart                | Come      | tom                  |                | Eckh           |                           | 7.            |               | ,                    |
|   | _       | FUNERAL DIRECTOR'S                    |                            | fer         | Fu40pressal            |           |                      | 24n REC'S      | D BY REGIST    |                           | STRAB'S SIGN  | JATURE.       | •                    |
|   | 73      | 1.1. W. W. 711.                       | 103                        |             | Main Fr                |           |                      |                | # # 3 # · ·    | '58 75                    | 0             | -             |                      |
|   | 1 1 1 1 | ALLENNA AT . LUVE                     | PLANTER CU                 | 110         | WEST 1 17 . 11 10      | 18 1.13   | Lack Color           | DATE           |                |                           | Jung 1. 0 184 | 1             |                      |



TO HOMETAL OR ATTENDING

VS A15 (4) 15M 10/57

14

12

### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**CERTIFICATE OF DEATH** 

5212

05216

Reg. Dist. No

|   | 1, PLACE OF DEATH  a COUNTY        |  | -               |                    | 2. USUAL RESI         | DENCE (Wh     | ere deceased     | lived If institution | n Residence   | befare ada   | mission)    |
|---|------------------------------------|--|-----------------|--------------------|-----------------------|---------------|------------------|----------------------|---------------|--------------|-------------|
|   | d COOMIT                           | Allegany   |                 | MARYLAND           | o STATE I             | Mary]         | land             | 6 COUNTY             | Alle          | gany         |             |
| F | b. CITY OR TOWN<br>RURAL and give  | (If outside corporate limits, v                            | vrite c. LEN    | GTH OF STAY IN 16  |                       |               |                  | ate limits, write R  | JRAL and give | e nearest to | own)        |
| 1 | Cum                                | perland  | 4,              | /16/58             |                       | Cumbe         | erland           | 1                    |               |              |             |
|   | d. NAME OF HOSP<br>OR INSTITUTION  | TAL (If not in hospital, give                              | street address) |                    | d STREET A            | DDRESS        |                  |                      |               | e. 15        | RES DENCE   |
|   |                                    |  | ounty           | Infirmar           | У                     | 723 N         | Maryle           | and Ave              | nue           | YES          | N A FARM?   |
|   | 3. NAME OF<br>DECEASED             | First  |                 | Middle             | Los                   | t             | 4. DATE          | Mon                  | h             | Day          | Year        |
|   | (Type or print)                    | Margar   | et El           | izabeth            | Rice                  |               | OF<br>DEATH      | Ma                   | y             | 21,          | 1958        |
|   | 5. SEX                             | 6. COLOR OR RACE 7.  | MARRIED         | NEVER MARRIED      | B. DATE OF BIRTI      |               | 9                | lost b chday)        | IF UNDER 1 Y  |              |             |
|   | Female                             | White w  | DOWED           | DIVORCED 🗌         | 8/21/                 | 1872          |                  | 85 yrs.              | Manths Do     | ys Hou       | es Min.     |
|   | 10a. USUAL OCCUPAT                 | ON (Give kind of work done<br>rking life, even if retired) | 10b. KIND O     | F BUSINESS OR INDU | STRY 11. BIRTHPL      | ACE (State    | ar foreign cou   | intry)               | 12 CITIZE     | N OF WH      | AT COUNTRY? |
|   | Housew:                            |  | Own             | Home               | Cumb                  | erlar         | nd, Ma           | ryland               | U.            | S.           | A •         |
|   | 13. FATHER'S NAME                  |  |                 |                    | 14. MOTHER'S          | MAIDEN N      | <b>EAME</b>      |                      |               |              |             |
|   |                                    | John Spea  | rman            |                    |                       | Man           | ry Cos           | grove                |               |              |             |
|   | 15 WAS DECEASED EV                 | ER IN U. S. ARMED FORCES                                   | 7 16. SOCIAL    | SECURITY NO. 17    | NFORMANT P            | . 0.          | Box C            | 99 Addr              | e Cumb        | erla         | nd Md.      |
| 1 | no                                 | In law Red and on common treatment                         |                 | AJ                 | legany                | Cour          | aty Ir           | firmar               | y Rec         | ords         |             |
| f | 18. CAUSE OF DE                    | ATH [Enter only one couse                                  | per line far (a | ). (b) and (c) }-  |                       |               | 3 -1             | ,                    |               | INTERVAL     | BETWEEN     |
| ı | PART I DE                          | ATH WAS CAUSED BY.   |                 | Ville              | con                   | 111           | Wed              | nr sta               | 210           | ONSET A      | ND DEATH    |
| 1 | 4 dedid                            | DUE TO   |                 | 20 -               | t .                   | /             | 11               | *                    | ,             |              |             |
| ı | Conditions, if                     | any, which )   | $\mathcal{C}$   | Lroz.              | 1                     | 20 11         | A res            | 1 Bet                | En            |              | >           |
| ı | gave rise to<br>couse (a), stating |  |                 | 1) (               | 0                     | 1             | 1                | . /                  | )             | (            |             |
|   | lying cause last.                  |  |                 | percer             | al i                  | ari           | tere             | osell                | 202           | 0            | -           |
|   | PART II OT                         | HER SIGNIFICANT CONDITI                                    | ONS CONTRIB     | UTING TO DEATH BUT | NOT-RELATED TO        | THETERMI      | NAL DISEASE      | CONDITION GIV        | EN IN PART 1  | (a) 19. W/   | AS AUTOPSY  |
|   | PART II OI                         | X les  | ucl             | e osl              | unco                  | re            | arr              | クス                   |               |              | RFORMED?    |
|   | 200. ACCIDENT W                    | AS UNDERLYING 206  | DESCRIBE HO     | OW INJURY OCCURRE  | D. (Enter nature a    | f injury in f | Part I ar Part I | I of item 18.)       |               |              |             |
|   |                                    | MEDICAL EXAMINER)  |                 |                    |                       |               |                  |                      |               |              |             |
|   |                                    | , ,  | 20d. INJURY C   |                    | ACE OF INJURY ()      | Home, form    | , 20f (City o    | or lawn)             | (Cau          | inty)        | (State)     |
|   | Hour a.m.<br>p.m.                  |  |                 | ot while 1994      | liony, street, britte | olog., elc.   | 1                |                      |               |              |             |
|   | 21. I certify t                    | hat I attended the de                                      | ceased fra      | 1/16/58            | . 19                  | to Ma         | ay 21,           | /58 <sub>19</sub>    | that I las    | t saw th     | a deceased  |
|   | alive an 5                         | /21/68   |                 | , and that death   |                       | 10:15         | R. from          | the course o         | ad on the     | data et      | ated above  |
|   | 011.0                              | A. II  |                 | 1 1                | geconed de            |               |                  | et, city or town,    |               | ddie si      | DATE SIGNED |
|   | ACTUAL<br>SIGNATURE                | Marie  | e-07            | 127                | early                 |               |                  | t.                   | 5.            | /22/         | 58          |
| 4 |                                    |  |                 |                    | M.O. Januarie         |               |                  |                      |               |              | <del></del> |
|   | PHYSICIAN'S<br>NAME (Type)         | Dr. James  | E. M            | cLean              | Cı                    | mber          | cland,           | Md.                  |               |              |             |
| 7 | 220 BURIAL, CREMATIC               | ON, 226. DATE THEREOF                                      | 22c N           | AME OF CEMETERY O  | R CREMATORY           |               | 22d. LOCATIO     | ON (City, Iown, o    | r caunty)     | 15           | itate)      |
|   | Burial Specify                     | 5-24-58  | H               | illcrest           | Burial                | Par           |                  | mberlar              |               |              | •           |
| 2 | 3. FUNERAL DIRECTOR                | 'S SIGNATURE   | AC              | DDRESS             |                       | 24a. REC'E    | D BY REGISTR     | AR 246 REGIS         | TRAR'S SIGN   | ATURE        |             |
|   | James F                            | . Scarpell:  | i, Cun          | berland,           | Md.                   | DATE M        | AY 2 3           |                      | 1             | 71           |             |



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CEPTIFICATE OF DEATH

| 1. PLACE OF DEATH O. COUNTY Allegary  MARYLAND D. CITY OR TOWN (if boulde capporete limits, write BURLA and give secrete form)  L. CITY OR TOWN (if boulde capporete limits, write BURLA and give secrete form)  L. CITY OR TOWN (if no lin hospical, give sivere address)  I. year  Cumberland  d. NAME OF HOSPITAL (if no lin hospical, give sivere address)  ALB Bond Street  Cumberland  d. STREET ADDRESS  ALB Bond Street  ALB Bond Street  First WIDDERASS  (if no lin hospical, give sivere address)  ALB Bond Street  ALB Bond Street  ALB Bond Street  First WIDDERASS  II. AD ATE DEATH MAGNY  ALB Bond Street  ALB Bond Street  ALB Bond Street  III. BRITHPLACE (Stole or foreign country)  The COUNTY Market of the bond of work down downing until a voting until a voting until a voting until a voting unit in voting unit, even if relified)  The COUNTY Allegary  ALB Bond Street  ALB Bond Street  ALB Bond Street  The DATE DEATH MAGNY  ALB Bond Street  The DATE DEATH MAGNY  ALB Bond Street  ALB Bond S |         | <u>_</u>                            | 50   | 112        | CERT              | rific.    | ATI    | OF DEATH                   | 1             |                                 | Reg. D   | ist. No   | 052      | 17        |
|--|---------|-------------------------------------|--|------------|-------------------|-----------|--------|----------------------------|---------------|---------------------------------|----------|-----------|----------|-----------|
| b. CITY OF TOWN (if outside corporate limits, write RURAL and give neorest frows)  Cumberland  d. NAME OF PATH (if outside corporate limits, write RURAL and give neorest frows)  1 year  Cumberland  d. NAME OF SISTERIAL (if no in hospital, give street address)  A STEET ADDRESS  NAME OF PATH (If outside corporate limits, write RURAL and give neorest flows)  1 year  A STEET ADDRESS  SEX  A STEET ADDRESS  SEX  B. COLOR OR RACE  THE OWN A FARMY TEST  Month  TO BERT  GUY  RICE  SEX NAME  B. COLOR OR RACE  NO. MICHAEL (In year)  A DATE OF SHITH  IN I  | 1.      | PLACE OF DEATH<br>o. COUNTY         | Allegany                                       | 10         | MA                | RYLAND    | 2.     | o. STATE                   |               |                                 |          |           |          | ion)      |
| Cumberland  d. NAME of Dispital (if me in hospital, give street address)  4.18 Bond Street.  4.19 Bond Street.  4.10 Bond Stree |         |                                     | outside corporate limi                         | ts, write  | c. LENGTH OF STA  | AY IN 1b  |        |                            |               | prote limits, write R           |          |           |          | )         |
| Als Bond Street  418 Bond Street  418 Bond Street  Als Bond Street  Test No Control Parkey  Both May  The Detay of Parkey  The Detay of Pa |         |                                     |  |            | l year            |           | ·      | Cumbe                      | rland         |                                 |          |           |          |           |
| DATE OF DECRAPS (Type or print)  NOBERT GUY RICE  S. SEX  ACCURROR RACE  Nober of Nober Asset  Nober of Nober of Nober Asset  Nober of Nober of Nober Asset  Nober of Nober of Nober of Nober Asset  Nober of Nobe |         | d. NAME OF HOSPIT<br>OR INSTITUTION |  |            |                   |           | 1      |                            |               | 4                               |          |           | ON A     | FARM?     |
| DEERAED COLOR OR RACE   GUY RICE   DEATH   May   3   19   58    5. SEX   S. COLOR OR RACE   7. MARRIED   DIVORCED   DIVORCED   Jan   18   1900   49   971.    100 USUAL OCCUPATION (Cive and of work a | 3.      | NAME OF                             |  |            |                   | lla       | Ш      |                            |               |                                 | sk.      | I         |          |           |
| Big   Note   Note   Note   Divorce   Jan   18, 1909   49   18   1909   1909   1809     |         | (Type or print)                     | OBERT  | . (        | GUY               | R         |        | 2                          | OF.           | May                             | 3        |           |          | 19 58     |
| DIO USUAL OCCUPATION (Give land of work and of low store and of low store and of work and of low store and stor | 5.      |                                     | 6. COLOR OR RACE                               | 7. MARK    | IED 🖺 NEVER MAR   | RIED 🔲    | 8. D.  | ATE OF BIRTH               |               | 9. AGE (In years last birthday) | -        |           | -        |           |
| Retired  Ret | L       |                                     | 41200  |            | Luf               |           |        |                            |               | 49 yrs.                         | 1        | Duys      | 110012   | mui,      |
| 13. FATHER'S NAME  | 10      | during most of work                 | N (Give kind of work ing life, even if retired | dane 10b.  | KIND OF BUSINESS  | OR INDU   | STRY   | 11. BIRTHPLACE (State      | ar foreign c  | ountry]                         | 12. C    | ITIŽEN C  | F WHAT   | COUNTRY   |
| HARTY G. Rice    Mary Jane Rowden  | _       |                                     |  | Di.        | eat Cutte         | r         |        |                            |               | ryland                          |          | _HS       |          |           |
| 15. WAS DECEASEDEVER IN U. S. ARMED FORCES?   16. SOCIAL SECURITY NO.   17. INFORMANT   418 Bond Street   17. INFORMANT   18. Co. Co. Co. Co. Co. Co. Co. Co. Co. Co   | 13.     | FATHER'S NAME                       |  |            |                   |           | 14     | . MOTHER'S MAIDEN N        | NAME          | - D                             |          |           |          |           |
| 15. WAS DECEASEDEVER IN U. S. ARMED FORCES?   16. SOCIAL SECURITY NO.   17. INFORMANT   18. Bond Address   18. Mary   18. Mary   18. Mary   18. Social security   19. Mary   1   |         |                                     | Harry G.                                       | Rice       |                   |           |        | Mary Jan                   | e Bow         | den                             |          |           |          |           |
| 18. CAUSE OF DATH   Enter only one course per line for (o), (b), and (c).     19. CAUSE OF DATH   Enter only one course per line for (o), (b), and (c).     19. CAUSE OF DATH   Letter was Caused by   Date to   Date    | 15.     |                                     |  |            | SOCIAL SECURITY N | 10. I7. I | NFO    | MANT                       |               |                                 | France   | +         |          |           |
| 18. CAUSE OF DEATH [Enter only one course per line for (o), (b), and (c).]  PART 1. DEATH WAS CAUSED BY.  DUE TO  Conditions, if any, which gave rise to Immediate cotie (o), stating the under. Jying course last.  (c)  PART 1. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO DECONTRIBUTION GOOD CONTRIBUTION GOOD CONTRIBU | Ĺ       |                                     |  |            | 17-10-101         | 8 Is      | oh     | elle Rice                  |               |                                 |          | _         | nd       |           |
| DUE TO  Conditions, if any, which gave rise to immediate covered out.  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?  PERF |         | 18. CAUSE OF DEA                    | TH [Enter only one co                          |            |                   |           |        |                            |               | <del></del>                     | -        | INT       | ERVAL BE | TWEEN     |
| Conditions, if any, which gave rise to immediate code (a), stating the under lying course last.  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED?, YES NO DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  20a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  20c. TIME OF INJURY Month, Day, Year Month, Day, Year Month, Day, Year Old INJURY OCCURRED (Industry, street, office bidg., etc.)  21. I certify that I attended the deceased from Month of work of  |         | PART 1. DEA                         | TH WAS CAUSED BY:                              | N          | Tuo I             | 1,2       |        | Ciron                      | ~             |                                 |          | ON        | part o   |           |
| Conditions, if any, which gave rise to immediate codes (a), stating the under lying cause last.  Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?, YES NO DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part II of item 18)  20c. ACCIDENT WAS UNDERLYING CONTRIBUTING CONTRIBUTION CONTR |         | 100.1                               |  |            |                   |           | ,      | /                          | ٨             |                                 |          | ,         | 7        |           |
| gaye rise to immediate codes (a), stating the under-lying cause last.  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?, YES NO DEATH II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?, YES NO DEATH II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?, YES NO DEATH II. FEITHER, NOTIFY MEDICAL EXAMINER;  20c. ACCIDENT WAS UNDERLYING TO COURSE DEATH II. FEITHER, NOTIFY MEDICAL EXAMINER;  20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While of work of injury in Part 1 or Part II of item 18.)  20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While of work of injury in Part II or Part II of item 18.)  20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While of work of injury in Part II or Part II of item 18.)  20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While of work of injury in Part I or Part II of item 18.)  20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While of work of injury in Part I or Part II or Item 18.)  20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While of work of injury in Part I or Part II or Item 18.)  20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While of work of injury in Part I or Part II or Item 18.)  20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While of work of injury in Part I or Part II or Item 18.)  20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED (Enter nature of injury in Part I or Part II or Item 18.)  20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED (Injury in Part I or Part II or Item 18.)  20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED (Injury in Part I or Part II or Item 18.)  20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED (Injury in Part II or Item 18.)  20c. |         | Conditions if a                     |  | P          | 41/2/             | le d      | (      | ochdin                     | L.            | to the                          |          |           | Carl     | 1         |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?, YES NO DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part II of item 18)  20a. ACCIDENT WAS UNDERLYING OCCURRED (Enter nature of injury in Part 1 or Part II of item 18)  20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED (Injury (Home, form, 20f. (City or town)) (State) (Injury of work) of work of wor |         | gaye rise to in                     | nmediate (                                     | -          | 0 200             |           |        | 1 1/1/1/2                  | - 0 V -       | مر الم                          |          | -         | 19 PV    | wyl.      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part II of item 18.)  20a. ACCIDENT WAS UNDERLYING DOWN CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  20c. TIME OF INJURY Month, Day, Year Mile of work of wo |         |                                     | the under-                                     |            |                   |           |        |                            |               |                                 |          |           |          |           |
| 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While of work of wor | NO      | -                                   | IER SIGNIFICANT CON                            | DITIONS C  | ONTRIBUTING TO D  | EATH BUT  | NOI    | RELATED TO THE TERMI       | NAL DISEAS    | E CONDITION GIV                 | EN IN PA | RT 1(a) 1 | 9. WAS   | AUTOPSY   |
| 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While of work of wor | 3       |                                     |  |            |                   |           |        |                            |               |                                 |          |           |          |           |
| 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While of work of wor | CERTIFI | OR CONTRIBUTING                     | CAUSE OF DEATH                                 | 20b. DES   | CRIBE HOW INJURY  | OCCURRE   | D (E   | nter nature of injury in I | Port 1 or Por | t II of item 18)                |          |           |          |           |
| 21. I certify that I attended the deceased from  | Š       | 20c. TIME OF INJUR                  | Y Month, Day, Yes                              | or 20d. It | NJURY OCCURRED    | 20e. PL   | ACE (  | OF INJURY (Home, farm      | , 20f. (Cih   | r or town)                      |          | (County)  |          | (State)   |
| 21. I certify that I attended the deceased from  | É       |                                     | 19   |            |                   | fo        | clory, | street, office bldg., etc. | 1             | ·                               |          | , , ,     |          | ,,        |
| olive on 1957, ond that death occurred of 1234 M/from the causes and on the date stated above ADDRESS (Street, city or town, state)  ACTUAL SIGNATURE 1958 M.D. May 3, 195  PHYSICIAN'S NAME (Type) George D. Simons M.D. 128 Union St. Cumberland Maryland  220 BURIAL CREMATION, REMOVAL (Specify) Removal (Specify) May 5, 1958 Hillcrest Burial Park Cumberland, Maryland  | 2       |                                     |  |            | 200               | -         | _      | - (3 h                     |               | . 7                             |          |           | _        |           |
| ACTUAL SIGNATURE MAY 3, 195  PHYSICIAN'S NAME (Type) George P. Simons M.D. 128 Union St. Cumberland Maryland  220 BURIAL CREMATION, REMOVAL (Specify) Burial May 5, 1958 Hillcrest Burial Park Cumberland, Maryland  220 BURIAL CREMATION, REMOVAL (Specify) May 5, 1958 Hillcrest Burial Park Cumberland, Maryland  |         | 3/23                                | of I affended the                              | deceas     | ~ -               | 7         |        |                            |               |                                 |          |           |          |           |
| ACTUAL SIGNATURE 2 25 May 3, 195  PHYSICIAN'S NAME (Type) George D. Simons M.D. 128 Union St. Cumberland Maryland  220 BURIAL CREMATION, REMOVAL (Specify) Burial May 5, 1958 Hillcrest Burial Park Cumberland, Maryland  Cumberland, Maryland   |         | olive on                            | ~~~~   | 12         | 2, ond the        | ot deoth  | 00     |                            |               |                                 |          | the da    |          |           |
| PHYSICIAN'S NAME (Type) George D. Simons M.D. 128 Union St. Cumberland Maryland  220 BURIAL, CREMATION, REMOVAL (Specify) Burial May 5, 1958 Hillcrest Burial Park Cumberland, Maryland  Cumberland, Maryland  Cumberland, Maryland  |         | ACTUAL (                            | 1 m  |            |                   |           |        | ·                          | ADDRESS (S    | treet, city or town,            | state)   |           | DA       | ATE SIGNE |
| NAME (Type) George P. Simons M.D. 128 Union St. Cumberland Maryland  220 BURIAL CREMATION, REMOVAL (Specify) Burial May 5, 1958 Hillcrest Burial Park Cumberland, Maryland   |         |                                     | - 1 / /  | 1/         | Jan M             |           | M.D.   |                            |               |                                 |          | Ма        | y 3      | 195       |
| 220 BURIAL CREMATION, REMOVAL (Specify)  Burial  220. NAME OF CEMETERY OR CREMATORY  Burial  221. LOCATION (City, town, or county)  (Stote)  Cumberland, Maryland  |         |                                     | George M.                                      | Simo       | ns M.             | D.        |        | 128_Unio                   | on_St         | Cumber                          | land     | N         | laryl    | and_      |
| Burial May 5, 1958 Hillcrest Burial Park Cumberland, Maryland  | 22      | BURIAL CREMATION                    | N, 226 DATE THEREC                             | )F         | 22c. NAME OF CE   | METERY O  | R CR   |                            |               |                                 |          |           |          |           |
|  | В       | urial (Specify)                     | May 5.   | 1958       | Hillcre           | st B      | uri    | ial Park                   | Cumba         | erland                          | Manu     | land      |          |           |
| 1240. REC 9 BL REGISTRANK   1492.REGISTRANG S STOLENIE   | 23.     | FUNERAL DIRECTORS                   | SIGNATURE                                      |            | ADDRESS           |           |        | 24a. REC'                  | D BY REGIST   |                                 |          |           |          |           |
| John J. Hafer, Cumberland, Maryland DATE MAY 6'58 Whereful   |         | John J. H                           | afer, Cuml                                     | perla      | nd, darv          | land      |        | DATE M                     | AY 6'         | 53 (                            | 3-22     | uch       |          |           |

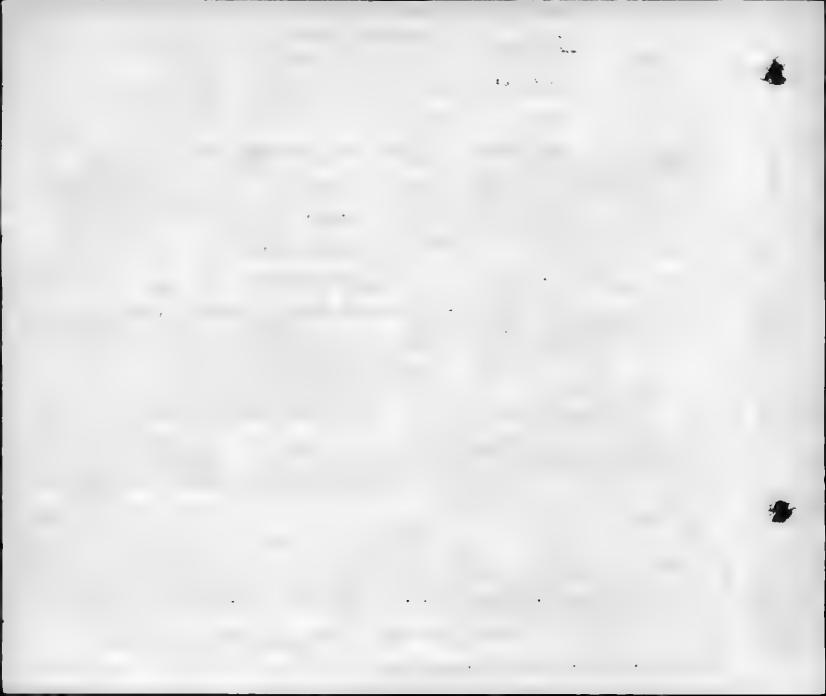
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page April may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After its certificate has been signed by the attending physician and completely fitted in by the funeral page 3 should be detached the use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 should be fatter prior to burial, cremation, ar removal, and in the registrar prior to burial, cremation, ar removal, and in the registrar prior to burial, cremation, ar removal, and in the registrar prior to burial, cremation, ar removal, and in the registrar prior to burial, cremation, are removal, and in the registrar prior to burial, crematically are removed. VS A15 (4) 15M 9/55

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iigned by the ottending physician and campletely filled in by the funeral filled in the please remave carbon papers. Pages 1 and 2 should be free in any event within 72 haurs affordeath.

r attending physicion. certificate has been sign a as the burial-transit p FUNERAL DIRECTOR: page 3 should be detact

VS A15 (4)

15M 10/57

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PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) p. COUNTY o STATE **b** COUNTY MARYLAND Allegany Maryl and Allegany CITY OR TOWN (If autside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside carporate limits, write RURAL and give negres) town) RURAL and give nearest lown) 6wks. 4 days Cumberland Cumber Land d NAME OF HOSPITAL (If not in haspita), give street address) d STREET ADDRESS e. IS RES DENCE OR INSTITUTION ON A FARM? 116 Bedford Street YES T NO TH Sacred Heart Hospital 3 NAME OF 4. DATE Middle Year DECEASED (Type or print) Williamx DEATH Rice 19 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE [In years IF UNDER 1 YEAR IF UNDER 24 HRS loss pittodos) Months Days Hours DIVORCED [7] WIDOWED | Male White 100 USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stole or foreign Egyptyon Grove Citizen OF WHAT COUNTRY? during most of working life, even if retired) Maryland. Retired Concrete Worker U.S. 13 FATHER'S NAME William C.Rice Katherine Brant 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT Address none Chart 18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c) ] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Congestive Heart Failure & Pneumonitis 30 hours 40000 DUE TO Arteriosclerotic Heart Disease with Cardiomegaly Canditions, if any, which gave rise to immediate DUE TO and coronary sclerosis Years cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? Advanced age: Macrocytic Anemia: Parkinsonism YES NO TO 206 ACC DENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part II or Part III of item 18.) 20c TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. While Not while at work of work ta May 21. 1958 that I last saw the deceased 21. I certify that I attended the deceased from April 5. , and that death accurred at 6.55 BM, from the causes and on the date stated above ADDRESS (Street, city or town, state) **DATE SIGNED** ACTUAL 5/22/58 Algonquin Hotel, Cumberland, Md SIGNATURE PHYSICIAN'S NAME (Type) Dr. W Doerner Algonouin Hotel Cumberland Md. 220. BUR AL, CREMATION, 22b. DATE THEREOF 22d. LOCATION (City, fown, or county) 22c. NAME OF CEMETERY OR CREMATORY (State) REMOVAL (Specify) 1958 Centenary Meth, Cemetery Allegany County, Maryland Burial 23. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 24a, REC'D BY REGISTRAR 246 REGISTRAR'S SIGNATURE DATEMAY 2 6 '58 John J. Hafer, Cumberland, Maryland



# TO MOSTITAL OF ATTERDING INVSICIAN: The fam requires that the death certificate be ensured within 24 hours offer death. Page 4 may be retained by the hospital ar attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral page 3 should be detached the use as the burial-transit permit. Then please remaye corban papers. Pages 1 and 2 should be the registrar priar to burial, cremation, ar remayal, and in any event within 72 haurs giver depth.

VS A15 (4) 85M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5215 CERTIFICATE OF DEATH

Reg. Dist. No. 05219

| _             |  |  |                 |                      |          |                                      |              |                        |                                   | 110 81               |              |                              |
|---------------|--|--|-----------------|----------------------|----------|--------------------------------------|--------------|------------------------|-----------------------------------|----------------------|--------------|------------------------------|
| T.            | PLACE OF DEATH O. COUNTY ALLEGANY  |  |                 | MARYL                | - 11     | 2. USUAL RESID<br>O. STATE<br>MARYLA |              | ere decease            | b. COUN                           | ution Residen        |              | dmission)                    |
|               | B. CITY OR TOWN (IF RURAL and give no CUMBERLAN                            | outside corporate limi<br>arest town)<br>D     | ts, write       | 79 DAYS              | V 16     |                                      | OWN (IF ou   |                        | rote limits, write                |                      |              | town)                        |
| ИΕ            | d NAME OF HOSP TA<br>OR INSTITUTION<br>MORIAL HOS                          |  |                 |                      |          | 628 MA                               |              | D AVE                  |                                   |                      | C            | RESIDENCE<br>ON A FARM?      |
| 3             | NAME OF<br>DECEASED<br>(Type or print)                                     | IRV  |                 | Middle<br>DANIE      | iL.      | RUDY                                 |              | 4. DATE<br>OF<br>DEATH | MA                                | onth<br>Y            | 28°°         | Yeor 58                      |
| 5.            | SEX<br>MALE  | 6. COLOR OR RACE                               | 7. MARI         | RIED NEVER MARRIED   |          | NOVEMBE                              | R 5          |                        | 9 AGE (In year<br>last birthdoy   | rs IF UNDER ) Months |              | JNDER 24 HRS.                |
| -             | o. USUAL OCCUPATION during most of worki                                   | N (Give kind of work on glife, even if retired | )               | KIND OF BUSINESS OR  |          | RY 11. SIRTHPLA                      |              | ***                    |                                   | 12 CIT               | S. A.        | HAT COUNTRY                  |
|               | FATHER'S NAME  |  |                 | <u> </u>             | P        | 14. MOTHER'S                         |              |                        |                                   |                      | 0 0 110      |                              |
|               | CHA  | RLES RUDY                                      |                 |                      |          |                                      | MARY         | HUTCH                  | ESON                              |                      |              |                              |
| 15.           | WAS DECEASED EVER  | IN U. S. ARMED FOR                             | CES? 16.        | SOCIAL SECURITY NO.  | 17. INF  | ORMANT                               |              |                        | A                                 | ddress               |              |                              |
|               | No   | yes, give wor or done or s                     | ervice]         |                      | MEN      | AORIAL H                             | OSPIT        | AL                     | CUM                               | BERLAN               | D. MD.       |                              |
| NC.           | Conditions, if on gove rise to im couse (o), stating the lying couse lost, | mediate DUE TO                                 | )               | CONTRIBUTING TO DEAT |          |                                      |              | NAL DISEAS             |                                   | SIVEN IN PAR         | 3            | AND DEATH                    |
| CERTIFICATION | 20a ACCIDENT WAS   |  |                 | CRIBE HOW INJURY OCC |          |                                      |              |                        |                                   |                      | . 98         | RFORMED?                     |
| MEDICAL CER   | 20c TIME OF INJURY   | AEDICAL EXAMINER)                              |                 |                      | Oe. PLAC | E OF INJURY (H                       | ome, form,   | 20f. (City             | or town)                          | (<                   | County)      | (State)                      |
| MED           | Hour o. m.<br>p. m.  | 19   | While<br>of wor | Not while            | FOCTO    | ry, street, office                   | piag., etc.) |                        |                                   |                      |              |                              |
|               | actual signature PHYSICIAN'S NAME (Type)                                   | of Pottended the R mmm                         | 195<br>STEGN    | E, and that d        | leath a  | , 19.55, occurred at                 | 9:411        | _M, fron<br>DDRESS (S) | n the causes<br>reet, city or tow | and an tl            | he date s    | tated above                  |
| 220           | REMOVAL (Specify) Burial   | May 31.  |                 | Island Hi            |          |                                      |              |                        | Paw Pa                            |                      | stc Va       | <sup>(Stote)</sup><br>rginia |
| 23.           | FUNERAL DIRECTOR'S   |  | 2000            | ADDRESS              | di di V  |                                      |              |                        | RARS 246 RE                       |                      | SNATURA      | ginia                        |
|               | John J. H  | afer, Cum                                      | berla           | and, Maryla          | and      |                                      | DATE J       | UN 2                   | 28                                | CO. Washing          | Note Comment |                              |



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DEPUTY MEDICAL EXAMINER: This certifine should be executed within 24 hours after deoth. If any delay is necessary, please xecute the certificate, which is moved "pending" in penal in Item, 18. Give Pages 1, 2, and 3 to the funeral director. Pages should be farworded to Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your file. FUNERAL DIRECTOR: It is should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Hear it is designated agent, prior to berial, cremation, ar removal, and in any event within 2 hours after death. 4 should be forworded 'TO FUNERAL DIRECTOR:

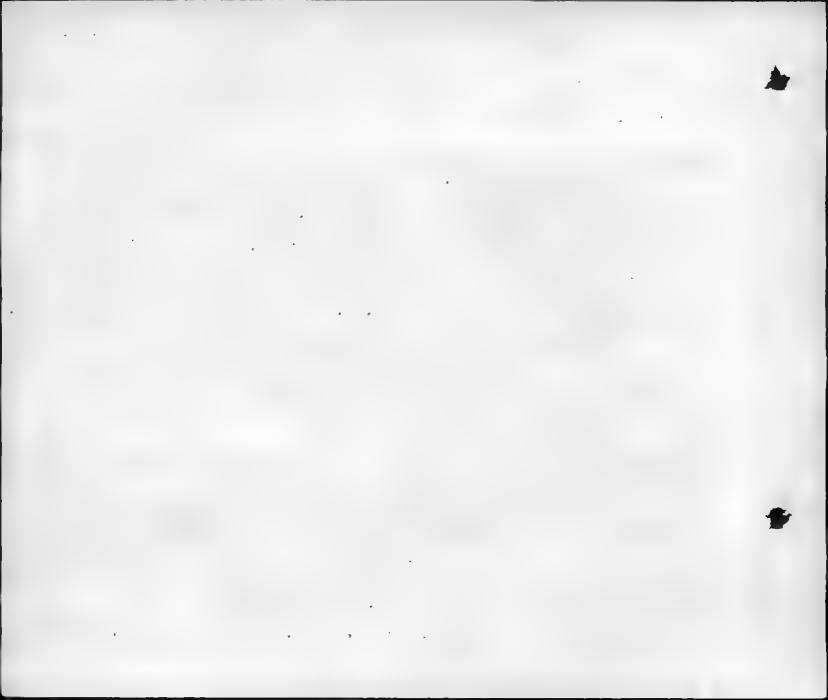
ar its designoled agent, p

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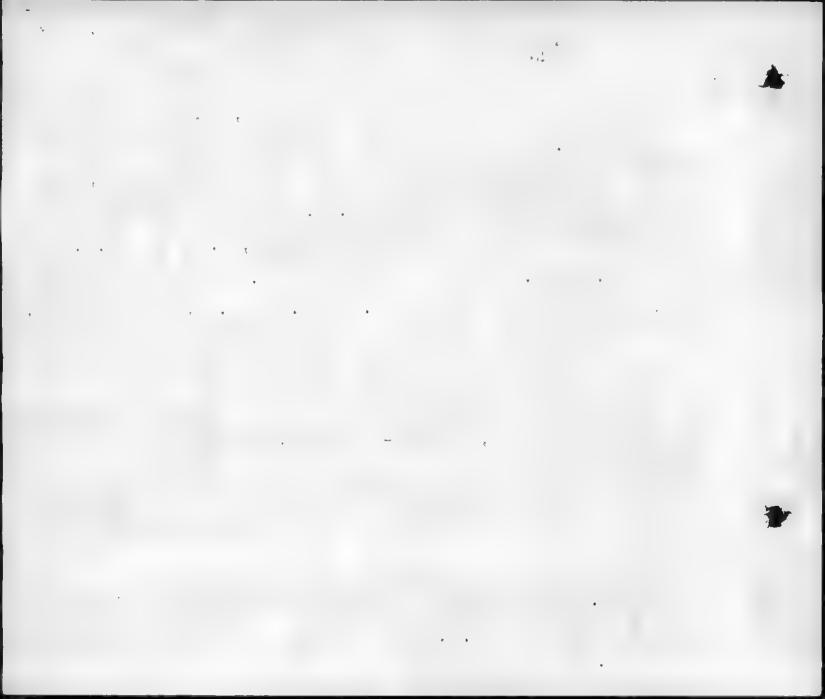
| MARYLAND STATE  | DEPARTMENT OF | HEALTH-BAL | TIMORE, 18 |
|-----------------|---------------|------------|------------|
| 521 CMEDICAL EX | AMINER'S CERT | IFICATE OF | DEATH      |

05220 Reg Dist No

|               |                                      |   |                  |  |          |                           |                                 |                     | Kag. 5131. 110     |                 |
|---------------|--------------------------------------|---|------------------|--|----------|---------------------------|---------------------------------|---------------------|--------------------|-----------------|
|               | PLACE OF DEATH                       |   |                  |  |          | 2. USUAL RESIDENCE        | (Where deceased                 | lived. If institut  | ion. Residence bel | lare admission) |
|               | AJ                                   | Llegany   |                  | MARYE  | AND      | o. STATE Mary             | yland                           | b. COUNTY           | All.ega            | ny              |
| 1             | ond give regreat town)               | outside corporate limits, with                      | - RURAL          | E. LENGTH OF STAY  | N lb     | c CITY OR TOWN            | (If autside carpor              | ate limits, write l | RURAL and give n   | ecrest lown)    |
|               | Route 3.0                            | lumberlan   | d                | 20 year  |          | Route                     | 3, Cum                          | berlan              | d                  |                 |
| 4             |                                      | L OR INSTITUTION (                                  | lf not in hospit | ol, give street address  | )        | STREET ADDRESS            |                                 |                     |                    | ON A FARM?      |
| _             | Bedford                              | Road_   |                  |  |          | / Bedro                   | rd Road                         |                     |                    | YES NO X        |
|               | NAME OF<br>DECEASED                  | Fir   | 21               | Middle   |          | Losi                      | 4 DATE                          | Month               | Doy                | Year            |
| -             | (Type or print)                      | LUELLA  |                  | ь.   |          | SIBERT                    | DEATH                           | May                 | 16,                | 19 58           |
| 5. 9          | SEX                                  |   | 7. MARRIED       | NEVER MARRIED  | □ B 1    | DATE OF BIRTH             | 9.                              | fact birthday)      | Manths Days        | IF UNDER 24 HRS |
|               | Female                               | White   | WIDOWED [        |  | 271      | ril 14,19                 | 900                             | 58 yrs.             | Additins Days      | Haurs Mir       |
| 100           | USUAL OCCUPATIO                      | N (Give kind of work :<br>p life, even if retired)  | dane 105 KIN     | ID OF BUSINESS OR II   | NDUSTR   | 11. BIRTHPLACE (Sto       | te or foreign cour              | stry)               |                    | F WHAT COUNTRY? |
|               | Housewif                             | e   | Ow.              | n Home   |          | Per                       | nna.                            |                     | USA                |                 |
| 13.           | FATHER'S NAME                        |   | I                |  |          | 14. MOTHER'S MAIDEN       | I NAME                          |                     |                    |                 |
| _             | Frank I                              |   |                  |  |          | CHKN                      | CLON                            |                     | E7 10 10 1 10 10   |                 |
| 15.<br>[Var   | WAS DECEASED EVE                     | R IN U.S. ARMED FO<br>(If yes, give wor or dates of | RCES? 16 SC      | CIAL SECURITY NO   |          | ORMANT                    |                                 | Address             |                    |                 |
|               | No                                   |   |                  | None   | Wm.      | R. Seibe                  | ert, Ro                         | ute 3,              | Cumber             | Land, Mo        |
|               |                                      | H [Enter only one cou                               | ise per line for | (o), (b), and (c).]  |          | 7                         | ,                               |                     | INTER              | YAL BETWEEN     |
|               | PART I. DEATH                        | H WAS CAUSED BY:<br>IMMEDIATE CAUSE (6)             |                  | remar  | 4        | O du                      | acon                            |                     | 15                 | weld .          |
|               | 420.1                                | DUE TO  | 1                |  | 1        | ^                         | +                               |                     |                    |                 |
|               | Canditions, if an                    |   |                  | orina.   | zy.      | Scherc                    | ~と11                            |                     |                    |                 |
|               | (a), stating the u                   |   |                  |  | 7        |                           |                                 |                     |                    |                 |
|               | couse fast.                          | ) (c)   |                  | The second of th |          |                           | - malauma, and a separate page. |                     |                    |                 |
| ğ             | PART II, OTHI                        | ER SIGNIFICANT CON                                  | DITIONS CON      | TRIBUTING TO DEATH   | BUT NO   | T RELATED TO THE TER      | MINALDISEASE C                  | ONDITION GIVE       | N IN PART I(0) 1   | PERFORMED?      |
| 3             |                                      |   |                  |  |          |                           |                                 |                     |                    | res No No       |
| CERTIFICATION | PRIMARY TO OF CON<br>CAUSE OF DEATH. | SE WAS<br>TRIBUTING []                              | 6 DESCRIBE H     | OW INJURY OCCURE   | RED (Ent | er nature of injury in Pi | ort I or Part II of             | Hem 18 }            |                    |                 |
| MEDICAL       | 20c. TIME OF INJUR                   | Y Month, Day, Yea                                   |                  |  | PLACE    | OF INJURY (Home, for      | rm, 20f (Cify or                | fown)               | (County)           | (State)         |
| MEE           | Hour o.m.                            | 19  | While at work    | Not while  | 100101   | y, sneet, orlice biog., a |                                 |                     |                    |                 |
|               | 21. I certify the                    | at I took charge                                    | af the rea       | mains described  | abav     | e, held an Autop          | osy , Insp                      | ection ,            | Inquiry []         | , and in my     |
|               | opinion death r                      | esulted fram: 1                                     | Natural ca       | uses []. Accid   | ent [    | , Suicide ,               | Hamicide [                      | ]. Undeter          | mined manne        | r 🖺             |
|               | X                                    | )   | R                | ( )  | /        | ,                         |                                 |                     |                    |                 |
|               | ACTUAL SIGNATURE                     | unde  | e Ton            | Skitari  | tic      | MAN CHIEF MEDICAL         | EXAMINER 🗍                      |                     |                    | DATE SIGNED     |
|               | EXAMINER'S                           | $\supset$   | 1                | ()   |          | ASSISTANT MEDI            | CAL EXAMINER                    | 3                   |                    |                 |
|               | NAME (Type)                          | Deved   | LICT             | SKITA  | SEL      | /C DEPUTY MEDICA          | L EXAMINER                      | 77 shich 99shi      |                    |                 |
| 220           | BURIAL CREMATION                     | N. 226 DATE THEREC                                  |                  | C. NAME OF CEMETER   |          |                           |                                 | N (City, fown, or   |                    | {State}         |
| -             | Burial                               | May 19,   | 1958             |  | emoi     | rial Cem.                 | Cumb                            | erland              | , L.d.             |                 |
|               | FUNERAL DIRECTOR'S                   |   |                  | ADDRESS  |          | 249. RE                   | C'D BY REGISTRAL                | 245 REGIST          | PAR'S SIGNATOR     | te .            |
|               | Byron Ki                             | ght, Cu   | nuberl           | and, Md.   |          | DATE                      | 1AY 1 9 '58                     | Ully.               | resuch             |                 |



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18



MARYLAND

c. LENGTH OF STAY IN 16

Blanche

Middle

DIVORCED [7]

lday

7. MARRIED T NEVER MARRIED

10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (Stale or foreign country) during most of working life, even if retired)

214-05-6389

WIDOWED [7]

e. IS RESIDENCE ON A FARM?

YES NO T

Yeor

1958

Allegany

Day

IF UNDER I YEAR IF UNDER 24 HPS

US.A

12. CITIZEN OF WHAT COUNTRY?

INTERVAL BETWEEN ONSET AND DEATH

26

Dovs

d STREET ADDRESS

Lost

Shafferman

8 DATE OF BIRTH

Chart

17 INFORMANT

o. STATE

Mary land

/98

W. Va.

14 MOTHER'S MAIDEN NAME

Oldtown

4. DATE

DEATH

2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission.)

c CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town)

**b.** COUNTY

Month

Address

Months

May

9. AGE (In years lost birthday)

KQ.

Terra Alta

Sara Benson

| be med with | M |  |
|-------------|---|--|
| 5 P         |   |  |

1. PLACE OF DEATH

Allegany

d NAME OF HOSPITAL (If not in haspital, give street address)
OR INSTITUTION

Marie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO

CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).)

6. COLOR OR RACE

Employed Memorial Hospital

MartThomas Epley

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (c)

Sacred Heart Hospital

b. CITY OR TOWN (If outside corporate limits, write

RURAL and give nearest town)

Cumberland

COUNTY

NAME OF

5. SEX

DECEASED (Type or print)

<u>Female</u>

3. FATHER'S NAME

No

age

25 in b filled Pages 1 and campletely papers. carbon offer

physician please remave o othending p ρ permit. day hat ar attending physicion. This certificate has been signed of use as the burial-transit permi

ATTENDING PHYSICIAN: The low mayim that the diath mert ficate be executed within 2 hours after death. may be retained by the hosp S FUNERAL DIRECTOR: A page 3 shauld be detached HOSPITAL OR 0 0 VS A15 (4) 15M 10/57

| 200. ACC DENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Part II of item 1B.)  20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or lown) (County)  4 Hour o.m.  20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or lown) (County)  4 Hour o.m.  21. I certify that I attended the deceased from 19.00, ta 20f. (City or lown) (County)  21. I certify that I attended the deceased from 19.00, ta 20f. (City or lown) (County)  21. I certify that I attended the deceased from 19.00, ta 20f. (City or lown) (County)   | TAI CEDTIES |                    | ( ( ) DUE TO ( )   | /                                 |
|--|-------------|--------------------|--|-----------------------------------|
| DUE TO    Some content of the property of the  |             |                    | Conditions, if any, which ) the  | 16.1                              |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 17 WAS AUTOPED CONTRIBUTING CAUSE OF DEATH OF CONTRIBUTING CAUSE OF CONTRIBUTION CAUSE OF CAUSE O   |             |                    | gove rise to immediate ( DISE SO   |                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUT PERFORM YES OF ACC DENT WAS UNDERLYING ON CONTRIBUTING AUSE OF DEATH OR CONTRIBUTION AUSE OF DEATH OR CONT |             |                    | lying saves lead   |                                   |
| 200 ACC DENT WAS UNDERLYING   20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 1B.)   20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED   20e. PLACE OF INJURY (Home, form.)   20f. (City or lown)   (County)   20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED   20e. PLACE OF INJURY (Home, form.)   20f. (City or lown)   (County)   4   4   4   4   4   4   4   4   4  |             | χ                  |  | I ID WAS AUTORSY                  |
| 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 10c. PLACE OF INJURY Home, form, 20f. (City or lown) (County)  Hour o. m. 19 While of work o |             |                    | 1 to real out at 17 1/2 14 A fine I de mais                                  | PERFORMED?                        |
| Hour o. m.  p. m.  19 While of work of |             | CERTIF             | LOK CONTRIOUTING LI CAUSE OF BEATH   |                                   |
| olive on 12 s, and that deoth occurred at ADDRESS (Street, city or town, stole)  ACTUAL  PHYSICIAN'S NAME (Type) Dr. S.G. Weisman  70. BURIAL CREMATION, 22b. DATE THEREOF 22c NAME OF CEMETERY OR CREMATORY PEMOVAL (Specify) Burial May 29, 1958 Terra Alta Cemetery Terra Alta, West Virginia  23 FUNERAL DIRECTOR'S SIGNATURE  ADDRESS 240. REC'D BY REGISTRAR 24b (REGISTRAR'S SIGNATURE)   |             |                    | Hour o. m. 18 While Not while factory, street, office bldg., etc.]           | unly) (State)                     |
| PHYSICIAN'S NAME (Type) Dr. S. G. Weisman  70. BURIAL CREMATION, 22b. DATE THEREOF PERMOVAL (Specify) Burial May 29, 1958 Terra Alta Cemetery Terra Alta, West Virginia  73 FUNERAL DIRECTOR'S SIGNATURE  ADDRESS (Street, city or town, slote)  DATE  M.D.  740. BURIAL CREMATION, 22b. DATE THEREOF  PEMOVAL (Specify) Burial May 29, 1958 Terra Alta Cemetery  ADDRESS 240. REC'D BY REGISTRAR 24b (REGISTRAR'S SIGNATURE)  |             |                    | 21. I certify that I attended the deceased from 1956, to 22, 1957, that I la | st saw the decease                |
| PHYSICIAN'S NAME (Type) Dr. S.G. Weisman  720. BURIAL, CREMATION, PEMOVAL (Specify) Burial May 29, 1958 Terra filta Cemetery Terra Alta, West Virginia  23 FUNERAL DIRECTOR'S SIGNATURE  ADDRESS  240. REC'D BY REGISTRAR 246 (REGISTRAR'S SIGNATURE)  |             |                    | ADDRESS (Street, city or fown stotal   | dote stated above:<br>DATE SIGNEI |
| NAME (Type)   Dr. S.G.   Weisman   59 Green Street   120c. BURIAL CREMATION   22b. DATE THEREOF   22c NAME OF CEMETERY OR CREMATORY   22d. LOCATION (City, lown, or county)   (Store)   Burial   May 29, 1958   Terra Alta Cemetery   Terra Alta,   West Virginia   23 FUNERAL DIRECTOR'S SIGNATURE   ADDRESS   240. REC'D BY REGISTRAR   24b REGISTRAR'S SIGNATURE  |             |                    | ACTUAL ATTLE LEW LELIS M.D.  | 121/5                             |
| Burial May 29, 1958 Terra Alta Cemetery Terra Alta, West Virginia  23 FUNERAL DIRECTOR'S SIGNATURE  ADDRESS  240. REC'D BY REGISTRAR 240 REGISTRAR'S SIGNATURE   |             |                    |  | turnet, bear                      |
| Burial May 29, 1958 Terra Alta Cemetery Terra Alta, West Virginia  25 FUNERAL DIRECTOR'S SIGNATURE  ADDRESS  240. REC'D BY REGISTRAR 246 REGIS |             | 220.               |  | (State)                           |
| 150  |             | 73                 | Burial May 29, 1958 Terra Alta Cemetery Terra Alta, West V                   | irginia                           |
| John J. Hafer, Cumberland, Maryland DATE JUN 2 '58 Willineduch   |             | 23 <sup>12</sup> 1 |  | IATURE                            |
|  | Į           | J                  | ohn J. Hafer, Cumberland, Maryland DATE JUN 2 '58 Cilinede                   | uch                               |
|  |             | Ī                  |  |                                   |



M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any deloy is necessory please execute the certificate, writing the word "pending" in pending in 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 shauld be farworded If the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained far yaur file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burightnays it permit. File pages 1 and 2 with the State Board of Hears or its designated agent, prior to burigh, cremation, optenwork, and in any event within 72 haurs ofter death.

VS. AT5ME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No

|   | 0 | 5 | 2 | 23 |  |
|---|---|---|---|----|--|
| 6 |   |   |   |    |  |

|               | PLACE OF DEATH                             | 0619   |               | 000000000000000000000000000000000000000 | 2 Office Bee        | MENIOS (14/L  | d                 | to a de to ata ata  | - Decidence be                          | for a delice of              |
|---------------|--|--|---------------|---|---------------------|---------------|-------------------|---------------------|---|------------------------------|
|               | . COUNTY                                   | Allegany   |               | MARYLAND                                | A PTATE             | Alabar        |                   | b. COUNTY           |   | ofore odmission) v           |
|               | . CITY OR TOWN (II.                        |  | Lillat        | c. LENGTH OF STAY IN 16                 |                     |               |                   | te Limits, write RL | Jeffer                                  | ***                          |
|               | and give negrest lown)                     |  |               | 1.0                                     |                     |               | ,                 | of Hithir Acids or  | Summ plan Black                         | reorest town;                |
| H-,           | Cumber                                     |  | f and in her  | 1 Day pitor, give street oddress)       | d STREET A          | Birmir        | igham _           |                     | 4                                       | e IS RESIDENCE               |
| ,             |  |  | I HOF IN NOS  | phot, give street oddress)              |                     |               | 70                |                     |   | ON A FARM?                   |
|               |  | 1 Hospital   |               |   |                     |               | · Prat            | <u> </u>            | -                                       | AER WO                       |
|               | NAME OF<br>DECEASED                        | Fire   | \$            | Middle                                  | Lost                | ]4            | OF .              | Month               | Doy                                     |                              |
|               | (Type or print)                            | Dewey  | -             |   | hannon              |               | DEATH             | May 3               |   | 1958                         |
| 5, 5          | EX   | 6. COLOR OR RACE                                   |               | D NEVER MARRIED B                       |                     |               | 9. /              | and Broadfackers b  | Aonths Days                             | Hours Min.                   |
| -             | Male Male                                  | White  | WIDOWED       |   | Apr. 10.            |               |                   | 60 yrs              |   |                              |
| 100           | USUAL OCCUPATION<br>luring most of working | N (Give kind of work i<br>i life, even if retired) | lone 10b K    | IND OF BUSINESS OR INDUST               | RY 11 BIRTHPLA      | ACE (Stote or | foreign count     | (7)                 | 12 CITIZEN C                            | F WHAT COUNTRY               |
| -             | Advance a                                  | gent   |               | Circus                                  | Broo                | ks. Ga        | la                |                     |   | U.S.                         |
| 13.           | FATHER'S NAME                              |  |               |   | 14. MOTHER'S        | MAIDEN NA     | ME                |                     |   |                              |
|               | Earnest P                                  | Shannon  |               |   | Leli                | a Dunb        | ar                |                     |   |                              |
|               | , no, er unknown)                          | R IN U. 5 ARMED FO                                 |               | SOCIAL SECURITY NO. 17, 1               | NFORMANT            |               |                   | Address             |   | e a ragoni                   |
|               |  | W.W. 2   | 4             | 16-05-3122 E                            | mer L.              | Kauffr        | lan               | Macon Ga            | l.                                      |                              |
|               | 18. CAUSE OF DEAT                          | H (Enter only one cou                              | se per line i | side day to                             |                     |               |                   |                     | INTE                                    | AVAL BETWEEN<br>ET AND DEATH |
|               | PART I. DEATH                              | WAS CAUSED BY:                                     | Co            | ronary Occlusi                          | on                  |               |                   |                     |   | sudden                       |
|               | 420.1                                      | DUE TO   |               | TOWNS TOWNS                             |                     |               |                   |                     |   | F2246544 7                   |
|               | Conditions, if on                          |  | Co            | ronary Scleros                          | is                  |               |                   |                     |   |                              |
|               | gove rise to immedi<br>(a), stating the u  | ote coute  |               |   |                     |               |                   |                     |   |                              |
|               | cause lost.                                | (c)  |               |   |                     |               |                   |                     |   |                              |
| Z             | PART II OTHE                               | R SIGNIFICANT CON                                  | DITIONS CO    | NTRIBUTING TO DEATH BUT N               | OT RELATED TO       | THE TERMINA   | ALDISEASE CO      | NOTION GIVEN        | IN PART 1(0)                            | IP. WAS AUTOPSY              |
| CERTIFICATION |  |  |               |   |                     |               |                   |                     |   | PERFORMED?                   |
| TIFIC         | 200. EXTERNAL CAUS                         | SE WAS 20  | b DESCRIBE    | HOW INJURY OCCURRED (E                  | nter noture of inj  | ury in Port I | or Port II of it  | em 18 )             |   |                              |
| 232           | PRIMARY OF CON<br>CAUSE OF DEATH.          | TRIBUTING []                                       |               |   |                     |               |                   |                     |   |                              |
| 3             | 20c, TIME OF INJUR                         | Month, Doy, Yes                                    | r 20d. I      | NJURY OCCURRED 200. PLA                 | CE OF INJURY (H     | lome, form,   | 20f. (City or 1   | own)                | (County)                                | (Slote)                      |
| MEDICAL       | Hour o.m.                                  | 19   | While         | Not while tech                          | ory, street, office | bidg., etc.)  |                   |                     |   |                              |
| 1             |  | at I took charge                                   |               | emoins described obo                    | ve. held on         | Autopsy       | XI Into           | ection DO           | Inquiry -                               | and in my                    |
|               |  |  |               | puses [7], Accident [                   | _                   | _             |                   |                     | , |                              |
|               | opinion death i                            | A  | 4010101       | A . Vicidelli [                         | , suicide           | , no          | militioe          | , Undetern          | пнев тапл                               | er 🔲                         |
|               | ACTUAL /                                   | In deal  | F X G         | Total al                                | CHIEF M             | EDICAL EXA    | AINER 🗇           |                     |   | DATE SIGNED                  |
|               | SIGNATURE_                                 | energy C1  | XX            | carece)                                 | , M.D               |               | EXAMINER [        |                     |   | 27                           |
|               | EXAMINER'S<br>NAME (Type)                  | Benedict Sl  | citare        | lic, M.D.                               |                     | MEDICAL EX    |                   | Ma                  | 43                                      | 1958                         |
| 220           | BURIAL CREMATION<br>REMOVAL (Specify)      | 276 DATE THEREC                                    | F             | 27c. NAME OF CEMETERY OR                | CREMATORY           | 2             | 2d LOCATION       | (Cily, town, or     | (ounty)                                 | (Stote)                      |
|               | Remova1                                    | 5/5/58   |               | Oakland Ceme                            | tery                |               | Birmin            | igham, A            | labama                                  |                              |
| 23            | FUNERAL DIRECTOR'S                         | SIGNATURE  |               | ADDRESS                                 |                     | 240. REC'D I  | Y REGISTRAR       |                     | AR S SIGNATU                            | RE                           |
|               | Charles L.                                 | George   | Cum1          | perland. Md.                            |                     | DATEMAY       | 6 '58             | 1 Cool              | · such                                  |                              |
|               | 4  | 2  | 1             |   |                     |               | المنازيب المؤسسات |                     |   |                              |

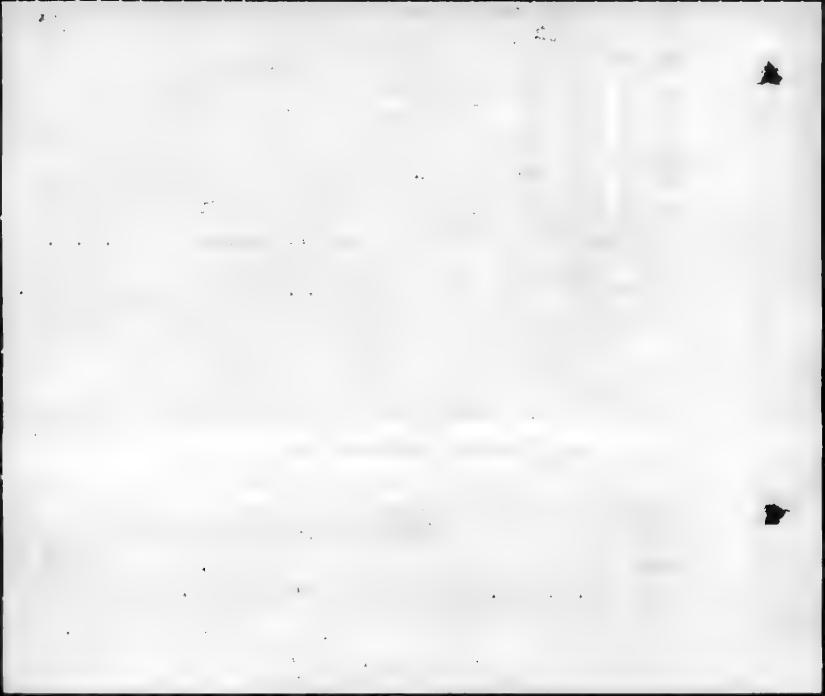


| ARYLAND STATE DEPARTMENT O | OF HEALTH—BALTIMORE, | 18 |
|----------------------------|----------------------|----|
|                            |                      |    |

5220 CERTIFICATE OF DEATH

Reg. Dist. No. () 5224

| 1   |  |                                 |   |                                     |   | Keg. Dist. N    | 0. () -() -(, -(, -(, -(, -(, -(, -(, -(, -(, -(, |        |
|---|--|---------------------------------|---|-------------------------------------|---|-----------------|---|--------|
| J. PLACE OF DEATH G COUNTY                    | Allegany   | MARYLA                          | 2. USUAL RESI                                   | DENCE (Where decease Maryland       | b. COUNTY   |                 | fore admission)                                   | ~      |
| RURAL and give n                              | If autside carparate fimits, writ<br>learest tawn)<br>Brland               | 1/20/58                         | 1   | IOWN (If outside cor<br>Barton      | porate limits, write RU                               | JRAL and give n | earest tawn)                                      |        |
| d NAME OF HOSPI<br>OR INSTITUTION             | TAL (If not in haspital, give stre<br>Allegany Cou                         | mty Infirme                     | d STREET A                                      | DDRESS<br>Maryland                  | ļ   |                 | e IS RESIDENC<br>ON A FARM<br>YES NO              | ?      |
| 3 NAME OF<br>DECEASED<br>(Type or print)      | Mary   | Middle K.                       | Smal.   |                                     | ***************************************               |                 | Day Year<br>1958                                  | 3      |
| Female  | 1  | ARRIED NEVER MARRIED            | 1 /- /-   | 877                                 | 9 AGE (In years lost birthday)                        | Menths Days     | AR IF UNDER 24 H                                  | IRS _  |
| 10a. USUAL OCCUPATIO                          | ON (Give kind of work done It<br>king life, even if retired)               | -                               | NOUSTRY IT BIRTHPL                              | ACE (State or foreign               | country)  |                 | OF WHAT COUN                                      | ATRY?  |
| 13. FATHER'S NAME                             |  |                                 |   | MAIDEN NAME                         |   |                 |   |        |
|   | John Symons  |                                 |   | riet Mic                            |   |                 |   |        |
| 15. WAS DECEASED EVE<br>[Yes. np. or unknown] | ER IN U. S. ARMED FORCES? (If yes, give wor or dates of service)           | 16. SOCIAL SECURITY NO          | 17. INFORMANT P                                 | .0.Box 5                            |   |                 | rland, Nords                                      | /ld    |
|   | ATH [Enter only one couse per<br>ATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) | r line for (a), (b), and (c) ]  | E myo   | cardet                              | le.   | 10              | TERVAL BETWEEN                                    | H<br>4 |
| Canditions, if a                              | mmediate (   | Cerch                           | el Er   | terrose                             | Cerosia   | 2 '             | >   |        |
| tying couse last.                             | the under-   | Hyp.                            | ertuis  | ion                                 |   |                 | ?   |        |
| PART II OTH                                   | HER SIGNIFICANT CONDITION  | IS CONTRIBUTING TO BEATH        | PER COL   | CLF 200                             | ASE CONDITION GIVE                                    | EN IN PART 1(a) | 19. WAS AUTOP<br>PERFORMED?<br>YES NO             | `i_/   |
|   | AS UNDERLYING [] 20b. D CAUSE OF DEATH MEDICAL EXAMINER)                   | PESCRIBE HOW INJURY OCC         | URRED. (Enter nature a                          | Finjury in Part I ar P              | ort II of item 18.)                                   |                 |   |        |
| 20c. TIME OF INJUR<br>Hour a. m.<br>p. m.     | Wh   |                                 | e PLACE OF INJURY (I<br>factory, street, office | lome, form, 20f. (C<br>bldg., etc.) | ity or town)  | (County         | y) (Sto   | ate)   |
| alive on5,                                    | not I attended the dece<br>/211/58 19                                      |                                 | 58 , 19<br>eath accurred at                     | 7:30Am, fro                         | 58 19<br>om the causes of<br>(Street, city or town, s | nd an the de    | saw the decedate stated ab                        | ave.   |
| SIGNATURE                                     | Juiles 1   | - Maleu                         | M.D   | 9 Greene                            | St.   | 5               | /26/58  |        |
| PHYSICIAN'S<br>NAME (Type)                    | Dr. James E  | . McLean                        | C   | umberlan                            | d, Md.  |                 |   | *      |
| BUT 9 1 (Specify)                             | 5/27,58  | Z2c. NAME OF CEMETER Laurel Hil |   |                                     | ATION (City, town, or SCOW,                           | r county)       | (State)   |        |
| 23. FUNERAL DIRECTOR                          | 'S SIGNATURE   | Westernport,                    | Md.   | DATE MAY 2 8                        |   | THAR'S SIGNATI  | NE.   |        |



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| ) | Ě        | TO FUNERAL DIRECTOR: I his certificate has been signed by the attending physicion and campletely filled in by the funeral rector | page II shauld be detach 1 use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shauld be 12 wit | the registrar briar to burial, cremotian, ar removal, and in ony event within 72 hours after death. |
|   | *        | }<br>6.15  | 10  |   |
| 1 | 5 N      | 9/   | 55  | -   |

|   |  | -41-4  |  |  |  |   |  | Madi bisi  | 110.   |  |
|---|--|--|--|--|--|---|--|--|--|--|
| PLACE OF DEATH  | gany   |  | MARYLA   | ND   | 2. USUAL RESIDENCE (WI   | here deceased   | lived. If institution b. COUNTY  |  |  | nission)   |
| RURAL and nive ne   | arest fown!  | s, write   |  | l 1b   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lown)  Westernport  |   |  |  |  |  |
| d. NAME OF HOSPIT   | L (If not in hospitol, g<br>First  | ive street o   | oddress)   |  | , d. STREET ADDRESS e. 15 RESIDE   |   |  |  |  | RESIDENCE<br>N A FARM?   |
| 3. NAME OF First DECEASED (Type or print) Walter  |  |  | Middle   |  | Smith  | 4. DATE<br>OF<br>DEATH  | May Mon  | fh   | Doy 27   | Year<br>19 58  |
| s. sex<br>Male  | 6 COLOR OR RACE<br>White   |  |  |  |  | 0   | 9. AGE (In years lost birthdoy)  |  |  |  |
| Miner   | N (Give kind of work o   | onel 10b.  | KIND OF BUSINESS OR  | INDUS  | Maryland   | or foreign co   |  |  |  | IAT COUNTRY?   |
| 3. FATHER'S NAME<br>William   | Smith  |  |  |  |  |   |  |  |  |  |
|   |  |  | SOCIAL SECURITY NO.  |  |  | icGeo-N   |  |  | l.   |  |
| FART 1. DEAT  422.  Conditions, if or gove rise to in couse (o), stating the typing couse lost. | TH WAS CAUSED BY: IMMEDIATE CAUSE (o  DUE TO  IV, which Inmediate he under: (c)  |  | Arton  | P SUTI   | clerusis   |   | CONDITION GIVE   | EN IN PART I   | J J  | RETWEEN NO DEATH   |
|   | CAUSE OF DEATH   | r 20d. IN  | JURY OCCURRED 2  | Oe PLA   | CE OF INJURY (Home, farm   | n, 20f (City  |  | (Co  | YES  | (Stote)  |
| actual signature  | at I attended the May 3-16  Bizz   | 195<br>24  | hardle.  | leath  | occurred at 336/   | A.M. fram   | the causes a   | nd an the  |  |  |
| 270 BURIAL, CREMATION<br>REMOVAL (Specify)<br>BUT La L  | 5/29/58  | F  | Philos   | ERY OR   |  | Wes   | ternport   |  | Md   | itole)   |
| 23. FUNERAL DIRECTOR'S  | SIGNATURE  |  | Westernport  | t, N   |  |   | ran 24b REGIS  | e to a   | 7  |  |
|   | b. CITY OR TOWN [IF gural ond give new Westernpo]  d. NAME OF HOSPITOR INSTITUTION 109  3. NAME OF DECEASED (Type of print)  5. SEX  Ma.le  100 USUAL OCCUPATION MINEY  13. FATHER'S NAME  William  15. WAS DECEASED EVER (Year no. or unknown)  18. CAUSE OF DEA:  FART 1. DEA!  Conditions, if on gove rise to in the couse (o), stoling to the couse (o), stoling | b. CITY OR TOWN (If outside corporate limit RURAL and give nearest town) Westernport  d. NAME OF HOSPITAL (If not in hospital, gor INSTITUTION 109 First  3. NAME OF DECEASED (Type or print) Walter  5. SEX 6 COLOR OR RACE Male White 100 USUAL OCCUPATION (Give kind of work of during most of working life, even if retired) MINDY  13. FATHER'S NAME William Smith 15. WAS DECEASED EVER IN U. S. ARMED FOR (Town no, or unknown) 110  18. CAUSE OF DEATH [Enter only one compart to the print of | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport  d. NAME OF HOSPITAL (If not in hospital, give street of OR INSTITUTION 109 First  3. NAME OF DECEASED (Type or print) Walter  5. SEX 6 COLOR OR RACE 7. MARR White WIDOWE  100 USUAL OCCUPATION (Give kind of work done 10b. Miner  13. FATHER'S NAME William Smith  15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16. (Two no, or wiknown) [If yes, give wor or datas of service) 170  18. CAUSE OF DEATH [Enter only one couse per limit for the print of th | b. CITY OR TOWN [if outside corporate limits, write RURAL and give nearest lown]  b. CITY OR TOWN [if outside corporate limits, write RURAL and give nearest lown]  We sternport  d. NAME OF HOSPITAL (If not in hospital, give street address)  OR INSTITUTION  3. NAME OF HOSPITAL (If not in hospital, give street address)  OR INSTITUTION  3. NAME OF DECEASED  OR OLOGO FIRST  Middle  Walter  5. SEX  6 COLOR OR RACE  Wildward of Wildward on Middle  White Wildward Divorced  100 USUAL OCCUPATION [Give kind of work done wildward on the working life, even if retired]  101 USUAL OCCUPATION [Give kind of work done wildward on the working life, even if retired]  102 USUAL OCCUPATION [Give kind of work done wildward on the wildward on the working life, even if retired]  103 FATHER'S NAME  William Smith  15 WAS DECEASEDEVER IN U. S. ARMED FORCES?  16. SOCIAL SECURITY NO.  17 PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a)  PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (b)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH  OR CONTRIBUTING CAUSE OF DEATH  UP TO CONTRIBUTING TO DEATH  OR CONTRIBUTING CAUSE OF DEATH  UP TO CONTRIBUTING TO DEATH  OR CONTRIBUTING CAUSE OF DEATH  UP TO CONTRIBUTING TO DEATH  OR CONTRIBUTING CAUSE OF DEATH  UP TO CONTRIBUTING TO DEATH  OR CONTRIBUTING CAUSE OF DEATH  UP TO CONTRIBUTING TO DEATH  OR CONTRIBUTING TO CAUSE OF DEATH  UP TO CONTRIBUTING TO DEATH  OR CONTRIBUTING TO CAUSE OF DEATH  UP TO CONTRIBUTING TO CAUSE OF DEATH  OR CONTRIBUTING TO CAUSE OF DEATH  UP TO CONTRIBUTING TO CAUSE OF DEATH  OR CONTRIBUTING TO CON | b. CITY OR TOWN (If outside corporate limits, write RURA) and give nearest town)  b. CITY OR TOWN (If outside corporate limits, write RURA) and give nearest town)  d. NAME OF HOSPITAL (If not in hospitol, give street oddress)  d. NAME OF HOSPITAL (If not in hospitol, give street oddress)  3. NAME OF DECEASED  (Itype or print)  6. SEX   6 COLOR OR RACE   7. MARRIED   NEVER MARRIED   DIVORCED    100 USUAL OCCUPATION (Give kind of work done low of wing most of working life, even if retired)  101 USUAL OCCUPATION (Give kind of work done low of wing most of working life, even if retired)  102 USUAL OCCUPATION (Give kind of work done low of wing most of working life, even if retired)  103 FATHER'S NAME  W1111am Smith  115 WAS DECEASED EVER IN U. S. ARMED FORCES?  116 SOCIAL SECURITY NO. 17. IN MIT OF MARRIED   DOR OF WORKING OF WO | D. CIV OR TOWN IT GOURGE corporate limits, write RURAL and over accept town!  D. CIV OR TOWN IT GOURGE corporate limits, write RURAL and over accept town!  D. CIV OR TOWN IT GOURGE CORPORATE CONSTITUTION  C. LENGTH OF STAY IN 10  C. CIV OR TOWN IT GOURGE CONSTITUTION  C. COLOR OR RACE  C. LENGTH OF STAY IN ID  Middle  Loss  Smith  Smith  Maryland  Loss  Smith  Maryland  C. LENGTH OF STAY IN ID  D. DATE OF BIRTH  Middle  Loss  Smith  Maryland  C. LENGTH OF STAY IN ID  D. DATE OF BIRTH  Maryland  C. LENGTH OF STAY IN ID  D. DATE OF BIRTH  Middle  Loss  Smith  Maryland  C. LENGTH OF SIGN IN IT  Smith  Maryland  C. LENGTH OF SIGN IN IT  Maryland  C. LENGTH OF STAY IN ID  D. DATE OF BIRTH  Maryland  C. LENGTH OF STAY IN ID  D. DATE OF BIRTH  Maryland  C. LENGTH OF STAY IN ID  C. CONTRIBUTION  C. TIME OF COLOR OR RACE  C. MARE OF STAY IN ID  C. CONTRIBUTION  C. | b. CIVY OR TOWN (If outside corporate limits, write build of the superior of give neoretic long was ne | D. COUNTY Allegany  b. CIV OR TOWN If outside corporate limits, write build of corporate limits, write build on going energy town of corporate limits, write build on going energy town.  C. ELENGTH OF STAY IN 16  C. CIV OR TOWN If outside corporate limits, write build on the corporate limits, write build buil | PLACE OF BEATH  O. COUNTY  Allegany  MARTLAND  D. CITY OF TOWN (II cutide copporate limit, write public of the county of the cou | PLACE OF BEATH   COUNTY   Allegary   Markland   C. LENGTH OF STAY IN 10   C. CITY OF TOWN [if conside corporate limits, write   C. LENGTH OF STAY IN 10   FURSAL OF STAY   C. CITY OF TOWN [if conside corporate limits, write   RURAL and give nearest   R. STAY   C. CITY OF TOWN [if conside corporate limits, write   RURAL and give nearest   R. STAY   C. CITY OF TOWN [if conside corporate limits, write   RURAL and give nearest   R. STAY   C. CITY OF TOWN [if conside corporate limits, write   RURAL and give nearest   R. STAY   C. CITY OF TOWN [if conside corporate limits, write   RURAL and give nearest   R. STAY   C. CITY OF TOWN [if consideration   C. CITY OF TOWN [if consideration   C. CITY OF TOWN [if consideration   C. CITY OF TOWN   C. CIT |



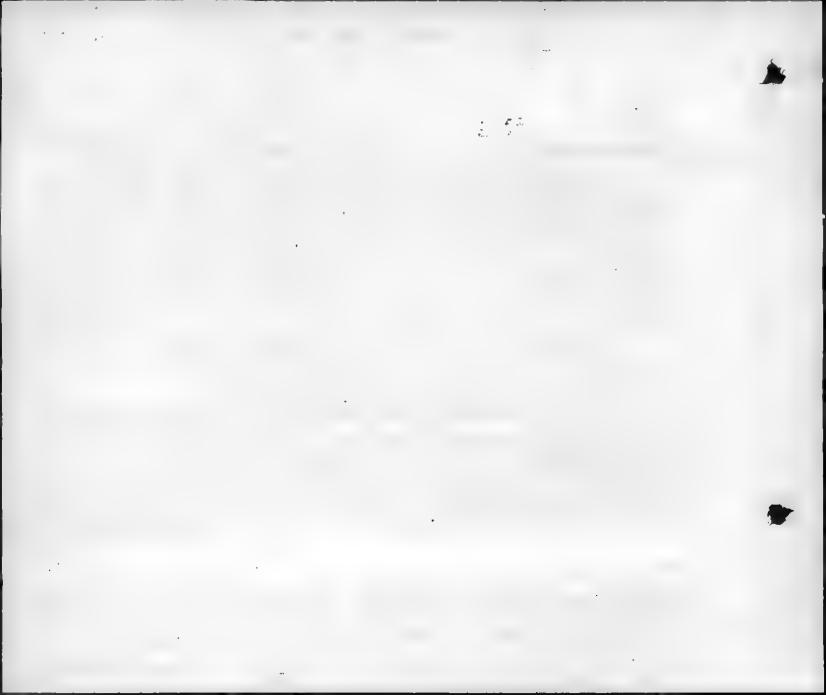
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 **CERTIFICATE OF DEATH** 5221 1. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission o. COUNTY o. STATE b. COUNTY MARYLAND TLEGANY MARYTA ND ALLEGANY b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) RURAL and give nearest town) CHARBORIAND HOURS CHMBERTIEND d NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION 61 ON A FARM? SARRED HEART HOSPITAT YES NO RUCT. TO PLACE Ξ Ü 3. NAME OF First Middle Lost 4. DATE Month Dov Yeor DECEASED OF DEATH (Type or print) CINDY 19 58 SMEATHEN MAY 5 SEX 9. AGE (In years last birthday) 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B DATE OF BIRTH IF UNDER TYEAR IF UNDER 24 HRS Manths Hours DIVORCED | FOMATE WHITE WIDOWED [ 26. yes. 10a. USUAL OCCUPAT ON (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or foreign country) during most of working life, even if retired) 12 CITIZEN OF WHAT COUNTRY? quo MD. Cumberland Infant Infant IISA after 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME RONALD SNEATHEN PATRICIA Thomas IS WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address 듄 no none PT'S CHARI 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH ā PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) #<u></u> DUE TO ρχ Ę ony Conditions, if ony, which burial-transit permi gove rise to immediate i.g **DUE TO** couse (o), stoting the underlying couse lost PART IF OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY CERTIFICATION PERFORMED? YES IN NO IT attending 200. ACCIDENT WAS UNDERLYING CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b DESCRIBE NOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.) 20c. TIME OF INJURY 20e, PLACE OF INJURY (Home, farm, 20f. (City or town) Doy, Year 20d. INJURY OCCURRED (County) (Stote) factory, street, office bldg., etc.) O. M. While Not while of work of work 21. I certify that I attended the deceased from 2-12-1, 19. 7, to 4-1-1, 19. 2 that I last saw the deceased \_, and that death accurred at \$200 \text{ M, from the causes and an the date stated above DIRECTOR: ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE å prior FUNERAL DIR PHYSICIAN'S NAME (Type) 22b. DATE THEREOR 22c. NAME OF CEMETERY OR CREMATORY 220. BURIAL CREMATION. 22d LOCATION (City, fown, or county) (State) REMOVAL (Specify) è Burial Zion Memorial Park Cumberland Maryland 0 23. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 246. REGISTRAR'S SIGNATURE 24a, REC'D BY REGISTRAR VS A15 (4) Hafer, Cumberland, Maryland DATE MAY 6 '58 15M 10/57 00016VXV

death.

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ATTENDIN

HOSPITAL



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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

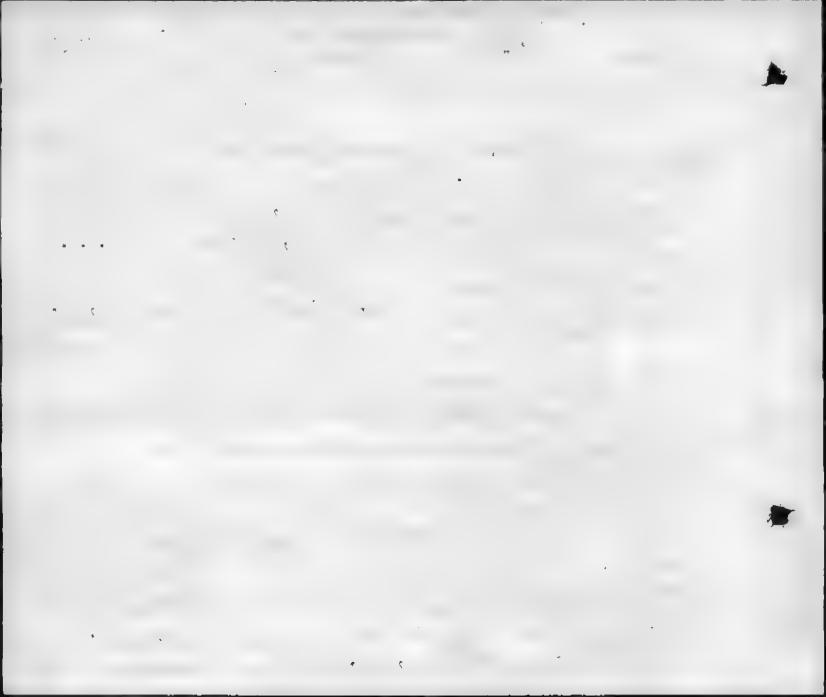
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| 32//   | Reg. Dist. No.  |
|--|---|
| 1. PLACE OF DEATH  O. COUNTY  ALLEGANY  MARYLANG   | 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  STATE MARYLAND  B COUNTY  ALLEGANY  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and a venegrest lown)  CUMBERLAND  1 DAYS  |   |
| d. NAME OF HOSPITAL (If not a hospitol, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES  | R.F.D.#1  o. 15 RESIDENCE on a FARM? YES \( \text{NO B2} \)   |
| 3 NAME OF First Middle (Type or print) ARCHIE B.   | SNYDER 4 DATE Month Day Yeor SNYDER MAY 17 19 58  |
| 5. SEX  6. COLOR OR RACE  7. MARRIED NEVER MARRIED DIVORCED DIVORCED   | JUNE 12, 1900   Dat birthdoy)   Months Days Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INI during most of working life, even if refired)  Retired Brakeman  Railroad  13. FATHER'S NAME   | DUSTRY 11. BIRTHPLACE (Stole or foreign country) HAMPSHIRE COUNTY, W.VA.  14. MOTHER'S MAIDEN NAME  |
| SAMUEL SNYDER  | LAURA MALCOLM   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 (Yes, no or unknown) (14 yes, give wor or dates of service) 705–05–9253  | Evelyn R. Snyder Oldtown, Md.   |
| 18. CAUSE OF DEATH [Enter only one couse per line for {o}, {b}, ond {c}.]  PART I DEATH WAS CAUSED BY  IMMEDIATE CAUSE {o}  DUE TO PERFURBING  Conditions, if ony, which  gove rise to immediate  couse {o}, stating the under.  lying couse lost.  Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH 8  | Stomach with onser and pentoristic lodaye and pentoristic lodaye and oferative 2 days   |
| TAN THE TOTAL TH | INTINOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOFEY PERFORMED YES NO PERFORMED YES NO PERFORMENT NOTICE OF INJURY IN PORT I OF PORT II OF I I I I I I I I I I I I I I I I I |
| 3 20c, TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e.  | PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Slote) foctory, street, office bldg, etc.)   |
| 21. I certify that I attended the deceased from  | th accurred at J2:05PM, from the causes and an the date stated abave  ADDRESS (Street, city or town, state)  M.D. Cumberland M.D. May 18'58   |
| 220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY  | or CREMATORY 22d. LOCATION (City, town, or county) (Stole) h. of Bro. Cem. Augusta, W. Va.  |
| James F. Scarpelli Cumberland, Md  | 24g. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE MAY 2 0 '58   |



deoth.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



VS A15 (4) 15M 10/57

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| N. | 199 |

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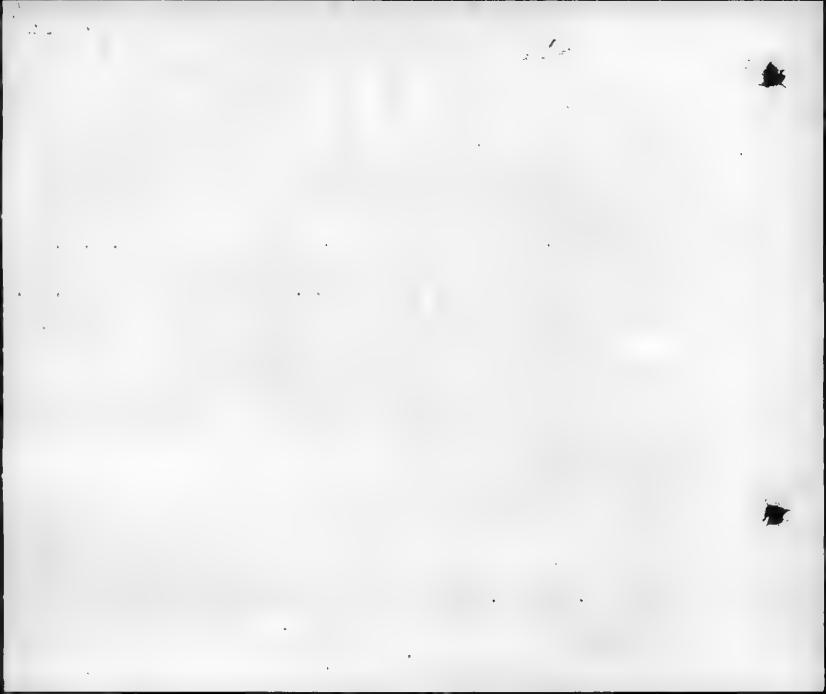
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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 5223

**CERTIFICATE OF DEATH** 

Reg. Dist. No. 115229

|           | ACE OF DEATH<br>COUNTY   |                 | MT 17 TO | il 0       | SUAL RESIDENCE       | (Where o    |                   | If institution R  | esidence befo | ore admission)                            |
|-----------|--|-----------------|--|------------|----------------------|-------------|-------------------|-------------------|---------------|---|
|           | Allegany   |                 | MARYLAND                                     |            | Marvla               | and         |                   |                   | legan         | V   |
| b.        | C TY OR TOWN (If outside corporate lim<br>RURAL and give negrest town)                                     | its, write      | c LENGTH OF STAY IN 16                       | c.         | CITY OR TOWN         | (If outsid  | le corporote lin  | nits, write RURAL | ond give ne   | orest town)                               |
|           | Cumberland   |                 | 6/9/53                                       | . 0        | of Cun               | mber        | land              |                   |               |   |
| d         | NAME OF HOSPITAL (if not in hospital, of INSTITUTION   | give street or  | ddress)                                      |            | . STREET ADDRES      |             |                   |                   |               | e. 15 RESIDENCE<br>ON A FARM?             |
|           | Allegany County  | Infi            | rmary  | BC         | X 155 (              | G111        | s Hil             | 1                 |               | YES NO V                                  |
| DI        | ECEASED  | rst             | Middle                                       |            | Last                 |             | DATE              | Month             | D             | ay Year                                   |
| (1)       | ype or print) Patri  | .ck             | Nichola                                      | s T        | ranum                |             | DEATH             | 5th               | I             | 3 1958                                    |
| 5. SE     | X 6. COLOR OR RACE   | 7 MARRIE        | ED NEVER MARRIED                             | B. DAT     | E OF BIRTH           |             | 9 AG              | E (In years IF 인  |               | R IF UNDER 24 HRS                         |
|           | Male White   | WIDOWED         | 275  | 17/        | 28/187               |             | 8                 | birthday) Mo      | nths Doys     | Hours Min                                 |
| 10a.      | USUAL OCCUPATION (Give kind of work during most of working life, even if retired                           | done 10b. K     | IND OF BUSINESS OR INC                       | DUSTRY 1   | 1. BIRTHPLACE (S     | Stote or fo | reign country)    | 1                 | 2 CITIZEN     | OF WHAT COUNTRY?                          |
|           | etired Railroade   |                 | ailroader                                    |            | Maryla               |             |                   |                   | U.            | S. A.                                     |
| 13 F/     | ATHER'S NAME   |                 |  | 14         | MOTHER'S MAID        |             | E                 |                   |               |   |
| B         | urbage Colema n  | Tran            | um   |            | Sar                  | ah W        | hite              |                   |               |   |
| 15. W     | AS DECEASED EVER IN U S ARMED FOR  | CES? 16. S      | OCIAL SECURITY NO. 17                        | INFORM     |                      |             | 599               | Addreys           | ımhen         | land, Md.                                 |
| [Yes. 1   | TO or unknown)   Iff yes, give war or dates of   | service)        | 9.2  |            | GANY CO              |             |                   | TOMADY            | רטים פ        | phe                                       |
| 1         | B. CAUSE OF DEATH [Enter only one co   | una man liaa    |  | والملائدة  | MANI O               | JUNI        | T TEAT.           | THUMET            |               | TERVAL BETWEEN                            |
| 1 1       | PART I. DEATH WAS CAUSED BY:   |                 | To    | 100        | 11                   | 111         | - +               |                   |               | SET AND DEATH                             |
|           | IMMEDIATE CAUSE (c   |                 | V Lana                                       | 47-11      | ry :                 | 4/1         | 100/1             | 260_              |               | //ks.                                     |
|           | 1422.2 DUE TO  | >               | ( ) - ·                                      | -          | the second           | 11/         | 11:3              | P                 |               | >   |
|           | Canditions, if ony, which a gove rise to immediate   | ,               | rond   | 0          | 1-4B                 | 61          | raes              | 20                |               |   |
|           | cause (o), stating the under-  |                 | Conster                                      | 16         | 11/2                 | ~ 1 °       |                   | 0 1 000           | ^             | ?   |
|           | lying couse lost.  | )               | resunce                                      | ar         | wire                 | ure         | -300              | wal.              | 7 1           | · · · · · · · · · · · · · · · · · · ·     |
| P         | PART II. OTHER SIGNIFICANT CON   | IDITIONS CO     | ONTRIBUTING TO DEATH B                       | UT NOT R   | EJATED TO THE J      | ERMINAL     | DISEASE CON       | DITION GIVEN I    | N PART 1(0)   | 19. WAS AUTOPSY PERFORMED?                |
| ₫         | 241  | uce             | e Dese                                       | 211        | oran                 | 100         | _ \               |                   |               | YES NO Z                                  |
|           | Og. ACCIDENT WAS UNDERLYING TO<br>OR CONTRIBUTING TO CAUSE OF DEATH<br>OF EITHER, NOTIFY MEDICAL EXAMINER) | 206. DESCI      | RIBE HOW INJURY OCCUR                        | RED. (Ente | er noture of injury  | y in Port I | l or Part 11 of i | tem 18.)          |               |   |
|           | Oc. TIME OF INJURY Month, Day, Ye  | or 20d, INJ     | JURY OCCURRED 20e                            | PLACE OF   | F INJURY (Home,      | form, 20    | Of (City or tow   | vn)               | (County       | ) (State)                                 |
| MEDICAL   | Hour o. m.   | While           | Not while                                    | foctory, s | treet, office bldg., | . elc.)     | , , , , ,         | •                 | (444)         | ,   |
| * -       | p. m   | or work         | □ di work □                                  |            |                      | - 1         | 4,110             | 1                 |               |   |
| $     ^2$ | 11. I certify that I attended the  | 3               |  |            |                      | - /         |                   |                   |               | aw the deceased                           |
|           | alive on 12/64/13/K  | <u>ک 19 , ـ</u> | E, and that dea                              | ith accu   | irred at 57          |             |                   |                   |               | ate stated above.                         |
|           | ( )/   | 6               | 62.10/                                       |            |                      | ADDI        | RESS (Street, ci  | ly or lown, state | )             | DATE SIGNED                               |
|           | IGNATURE ACCELO  | La.             | Thear  | GMD.       |                      |             | 49 G:             | reene             | Stree         | t 5.143                                   |
|           | HYSICIAN'S   | (L)             |  | •          |                      |             |                   |                   |               | Property of the state of the state of the |
|           | IAME (Type) Dr. Jame   | s E.            | McLean                                       |            | Guml                 | berl        | and.              | Marylan           | ad            |   |
| 22o.      | BUR AL. CREMATION, 226. DATE THEREC  | )F              | 22c NAME OF CEMETERY                         | OR CREA    |                      |             |                   | ity, town, or co  |               | (Stote)                                   |
| Ri        | REMOVAL Specify May 16   | ,1958           | Allegany                                     | Cou        | nty Cer              | - 1         |                   | erland            |               |   |
| -         | INERAL DIRECTOR'S SIGNATURE  |                 | ADDRESS                                      |            |                      | REC'D BY    | REGISTRAR         | 24b / REGISTRA    | R'S SIGNATI   | JR/E                                      |
| E         | yron Kight Cu  | mberl           | land, Md.                                    |            | DATE                 | BEAV        |                   | Cle 4             | -educ         | h   |
|           |  |                 |  |            | DAIL                 |             |                   | D 7 - 11          |               |   |



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5236 CERTIFICATE OF DEATH

05230

| 1 PLACE OF DEATH                     |  |               |                          |          | 2 USUAL RESIL        | DENCE (Wh   | ere deceased  | lived if instituti             | on Residence | before ad  | mission)    |
|--------------------------------------|--|---------------|--------------------------|----------|----------------------|-------------|---------------|--------------------------------|--------------|------------|-------------|
| 877                                  | egany .  | •             | MARY                     | LAND     |                      | Marv        | land          | b. COUNTY                      | Alle         | egan       | V.          |
| b CITY OR TOWN (If RURAL and give no | outs de corporate limi                         | ts, write     | c LENGTH OF STAY         | IN 1b    | c. CITY OR 1         | OWN (If o   | utside carpo  | rate limits, write R           | URAL and gi  | ve negrest | own)        |
| Frost                                |  |               | 18 day                   | S        | A M                  | t. S        | avage         | 9                              |              |            |             |
|                                      | AL (If not in hospital, g                      | ive street    |                          |          | d. STREET A          |             |               |                                |              | e. IS      | RESIDENCE   |
|                                      | s Hospita                                      | 1             |                          |          | Four                 | dry         | Row           |                                |              |            | N A FARMS   |
| 3. NAME OF<br>DECEASED               | Fir  | st            | Middle                   |          | Los                  |             | 4. DATE<br>OF | Mon                            | th           | Doy        | Yeor        |
| (Type or print)                      | Jame   |               | L.                       |          | Uhl                  |             | DEATH         | Ma                             | У            | 3rd,       | 19 58       |
| 5. SEX                               |  | 7- MARE       | RIED NEVER MARRIE        | D 🔲      | B DATE OF BIRTI      | 4           |               | 9 AGE (In years lost birthday) |              |            | NDER 24 HRS |
| Male                                 | White  | WIDOW         | ED DIVORCE               |          | Sept.1               | 2th,        | 1892          | 65 m                           | Months [     | Poys Ho    | urs Min,    |
| 10a. USUAL OCCUPATIO                 | N (Give kind of work ing life, even if retired | done 100.     | KIND OF BUSINESS O       | R INDU   | TRY 11. BIRTHPL      | ACE (State  | or foreign ci | ountry)                        | 12 CITIZ     | EN OF W    | HAT COUNTRY |
| Maintenan                            |  | f.            | feta fire                | 16º2     | • Ma                 | rvlar       | hd            |                                |              | TISA       |             |
| 13. FATHER'S NAME                    |  |               |                          | ·        | 14. MOTHER'S         | 77-1-16     | 4 77          |                                |              | UDA        |             |
| Charle                               | s R. Uhl                                       |               |                          |          | A74                  | o Ho        | ltzm          | 2 22                           |              |            |             |
| 15. WAS DECEASED EVE                 | IN U S ARMED FOR                               |               | SOCIAL SECURITY NO       | 17 H     | NFORMANT             | 20 XX       | <u> </u>      | Add                            | ress         |            |             |
| (Yes, no or unknown)<br>Yes          | W.W. I   | 2             | 20-16-565                | 3 M      | irs. Jai             | mes I       | . Uh          | 1, Mt.                         | Sava         | ge, M      | Id.         |
| 18. CAUSE OF DEA                     | TH [Enter only one co                          | use per l'    | ne for (p), (b), and (c) | ,        | 11 5                 | )           |               |                                |              |            | L BETWEEN   |
|                                      | TH WAS CAUSED BY IMMEDIATE CAUSE (6            |               | EX 9 BAI                 | 11       | 11/1/1               | 011         | mo            | nea                            |              | ONSET A    | NO DEATH    |
| 586X                                 | DUE TO   | 6/5           |                          | 11       | 0                    |             |               |                                |              |            | and,        |
| Conditions, if or                    | sv. which )                                    | . "           | Kipos                    | 10       | ndin                 | 2           |               |                                |              | Sen        | eul         |
| gove rise to in                      | mediote (                                      | -             | 11/0                     |          | 7                    |             |               |                                |              |            | 120110      |
| lying couse lost.                    | he under-                                      | $\mathcal{L}$ | KAVOI                    | 15       | TOA 1                | 19-12       | Les           |                                |              | 5-11       | Var         |
|                                      | ER SIGNIFICANT CON                             | DITIONS       | ONTRIBUTING TO DE        | H BUT    | NOT RELATED TO       | THE PERMI   | AL DISEASI    | E CONDITION GIV                | EN IN PART   | 1(a) 19. W | AS AUTOPSY  |
| PART II. OTH                         | <  | - 46          | 0                        |          |                      |             |               |                                |              | PE         | REORMED?    |
| 200. ACCIDENT WA                     | S UNDERLYING [                                 | 20b. DES      | CRIBE HOW INJURY OF      | CCURRE   | D. (Enter nature o   | injury in P | ort I or Parl | 11 of item 18.)                |              |            |             |
| UR CONTRIBUTING                      | MEDICAL EXAMINER)                              |               |                          |          |                      |             |               |                                |              |            |             |
| 3 20c TIME OF INJUR                  | Month, Day, Yea                                | or 20d II     | NJURY OCCURRED           | 20e. PL/ | ACE OF INJURY (      | lome, form, | 20f (City     | or lown)                       | ĮCo          | unty)      | (Stole)     |
| 20c TIME OF INJUR                    | 19   | While         | Not while                | for      | tory, street, office | bldg., etc. | )             |                                |              |            | (,          |
|                                      | . 1  |               | 11 6                     | 1/       | 15 10 26             | 2. 5        | ndea          | 2                              | 2            |            |             |
| 1 un                                 | at I attended the                              | deceas        | . —                      |          | 4 19.4.S.            | 10_2        | Jay.          | 2 19:22                        | -            |            | he deceased |
| alive an                             | ay 5   | _, 19_        | and that                 | death    | accurred at          |             |               | the causes o                   |              | e date si  |             |
| ACTUAL                               | 10/4   | nc            | / uma                    |          |                      | 1-          | ADDKESS (SI   | reel cultior lown,             | slate)       | in         | DATE SIGNED |
| SIGNATURE                            | 11/1/1   | 1-6           | ANT CE                   |          | M.D                  |             | YOU           | 10cm                           |              | 1110       | 4)          |
| PHYSICIAN'S<br>NAME (Type)           | WOM  | 70            | Lare                     | M        | 140                  |             |               | mdl                            |              | 14         | 138         |
| 220 BURIAL CREMATION                 |  | F             | 22c NAME OF CEME         | TERY O   | R CREMATORY          |             | 22d. LOCAT    | ION (City, town,               | or county)   | ł          | Store)      |
| Bunya (pecity)                       | 5-6-58   |               | Method:                  | ist      | Cemete               |             |               | Savage.                        |              | •          | Md.         |
| 23. FUNERAL DIRECTOR'S               | SIGNATURE                                      |               | ADDRESS                  |          |                      |             | BY REGIST     |                                | TRAR'S SIGN  | NA JURE    |             |
| Joseph I                             | R. Durst,                                      | Fro           | stburg,                  | Md       |                      | DATEMAY     | 5 '5          | 8 (m)                          | sauce        | . 2        |             |



VS ATS (4) TSM 10/S7



| MARYLAND | STATE | DEPART   | MENT | OF HEAL | TH-BALTIMO | RE, 1 |
|----------|-------|----------|------|---------|------------|-------|
| £99°     | 7 (   | CERTIFIC | CATE | OF DEA  | TH         |       |

Rea, Dist. No I. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY b. COUNTY Allegany MARYLAND Maryland Allegany. b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) 7 Hours Rd. 2, Frostburg, Fros tburg d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARMS Miner's Hospital (Box 11 YES NO. 3. NAME OF Middle 4. DATE Month DECEASED Pirillo Via (Type or print) Maria May 19 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS lost birthday) Months Days Hours Min. 6. COLOR OR RACE 7 MARRIED NEVER MARRIED TO B DATE OF BIRTH 5 SEX May 21st, 1876 White F'emale MIDOMED I DIVORCED | 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stole or foreign country) 12 CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Housework U.S.A. Own Housework Italv 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Serafina Soluri Pasquale Pirillo 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16 SOCIAL SECURITY NO Address 216-03-4325 Mrs.Freda Eagan, Rd. 2, Ftbg., Md., Box 117 1B. CAUSE OF DEATH [Enter only one couse per line far (a), (b), and (c). ONSET AND DEATH PART I, DEATH WAS CAUSED BY IMMEDIATE CAUSE (o). FARUMONIA **DUE TO** Conditions, if any, which gove rise to immediate DUE TO cause (a), stating the underlying couse last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED? 10-624124,2C YES NO 200. ACCIDENT WAS UNDERLYING OF CONTRIBUTING CAUSE OF-DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.) 20c. TIME OF INJURY Month. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (State) factory, street, office bldg\_ etc.) Hour o. m. While Nat while of work □ 21. I certify that I attended the deceased from Missing 25 . 19.55, to Missing 19.55 that I last saw the deceased

\_, and that death accurred at 1231 D.M. from the causes and on the date stated above. ADDRESS (Street, city or town, stote) ACTUAL SIGNATURE Exc. A Dechard

220 BURIAL, CREMATION, 226. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d LOCATION (City, town, or county) St. Michael's Cemetery Frostburg,

23 FUNERAL DIRECTOR'S SIGNATURE

Joseph R. Durst.

ADDRESS Frostburg, Md.

240 REC'D BY REGISTRAR DATE JUN 2

245 REGISTRAR'S SIGNATURE

(Stote)

Md.

VS A15 141 15M 10/57



VS A15 (4) 15M 10/57

| IARYLAND STATE DEPARTMENT | OF HEALTH-BALTIMORE, 1 | 1 |
|---------------------------|------------------------|---|
|---------------------------|------------------------|---|

5224 **CERTIFICATE OF DEATH**  Reg. Dist. No. 05232

| 1. PLACE OF DEATH  o. COUNTY  AL                               | LEGANY  | M                    | ARYLAND   | 2. USUAL RESIDENCE (WO. STATE PENNS                    | here deceased live     | d. If institution<br>b. COUNTY | Residence befor   | _                                |
|--|---|----------------------|-----------|--|------------------------|--------------------------------|-------------------|----------------------------------|
| RURAL and give he CUI  | MBERLAND  | 37 DAY               |           | c. CITY OR TOWN (IF<br>ME.YE!                          | outside corporole l    | hmits, write RUF               | RAL ond give neo  | rest town] V                     |
| d, NAME OF HOSPIT.<br>OR INSTITUTION                           | MEMORIAL HOS  |                      |           | d. STREET ADDRESS ROUTE                                | £ #2,                  |                                |                   | on a FARM?  YES NO               |
| 3. NAME OF<br>DECEASED<br>(Type or print)                      | First<br>H I LDA  | Mit                  | ddle<br>C | WERNER   | 4. DATE<br>OF<br>DEATH | Month<br>M/                    | /                 | _                                |
| 5. SEX<br>FEMALE   | 0.00.00.000   | AARRIED (X) NEVER MA | RCED   8  | JULY 8. 19   |                        | GE (In years II                |                   | F UNDER 24 HRS Hours Min.        |
| 10a USUAL OCCUPATION during most of work HOUSE /               | N (Give kind of work done no life even if refired)                  | T HOME               |           | TRY 11 BIRTHPLACE (Stole PENNSYLV)                     |                        | 1)                             | U. S.             | F WHAT COUNTRY                   |
| 13. FATHER'S NAME  | · · · · · · · · · · · · · · · · · · ·                               |                      |           | 14 MOTHER'S MAIDEN                                     |                        | ******                         |                   |                                  |
| JOHN W. BI   | DYER  |                      |           | MARGARET   | T SASS                 |                                |                   |                                  |
|  | IN U.S. ARMED FORCES?<br>I yes, give wor or dates of service)       | 16. SOCIAL SECURITY  |           | FORMANT<br>MEMORIAL HOSE                               |                        | Addres<br>CUMBER               | RLAND, M          | D.                               |
| 200 ACCIDENT WA  | mediate but To  ER SIGNIFICANT CONDITIO  GUNDERLYING CAUSE OF DEATH |                      |           | NOT RELATED TO THE TERM                                |                        |                                | 1 IN PART 1(o) 15 | P. WAS AUTOPSY PERFORMED? YES NO |
| U (IF EITHER, NOTIFY )  20c. TIME OF INJURY  Hour o. m. p. m.  | Month, Doy, Year 20   | d. INJURY OCCURRED   | 20e PLA   | CE OF INJURY (Home, formory, street, office bldg., etc | n, 20f (City or to     | >wn]                           | (County)          | (State)                          |
|  | 19 ot   | work at work         |           |  |                        |                                |                   |                                  |
| 21. I certify the  | t attended the dec  |                      |           | 7 - 19 <u>58</u> , to                                  | 2.76                   | 21, 19 20,                     | that I last so    | w the deceased                   |
| ACTUAL SIGNATURE   | W.J.  | Villea               | hat death | occurred of 3: 10F                                     | ADDRESS (Street,       | e causes an                    | d on the dat      | DATE SIGNED                      |
|  | R. W. F. WIL  |                      |           |  |                        |                                |                   |                                  |
| 270 BURIAL CREMATION  BENEVAL (Specify)  23 FUNERAL DIRECTOR'S | 5/24/58   | HAY'S CH             |           | CEMETERY   | MEYEN                  | SDAL                           | E, PEN            | (Stole)                          |
| 143 FOINERAL DIRECTORS   | AUS MA  | ∧DDK£22              |           | LOA- REC   |                        | 1 TABLE DECLICATION            | RAR'S SIGNATUR    | E .                              |



HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 5995

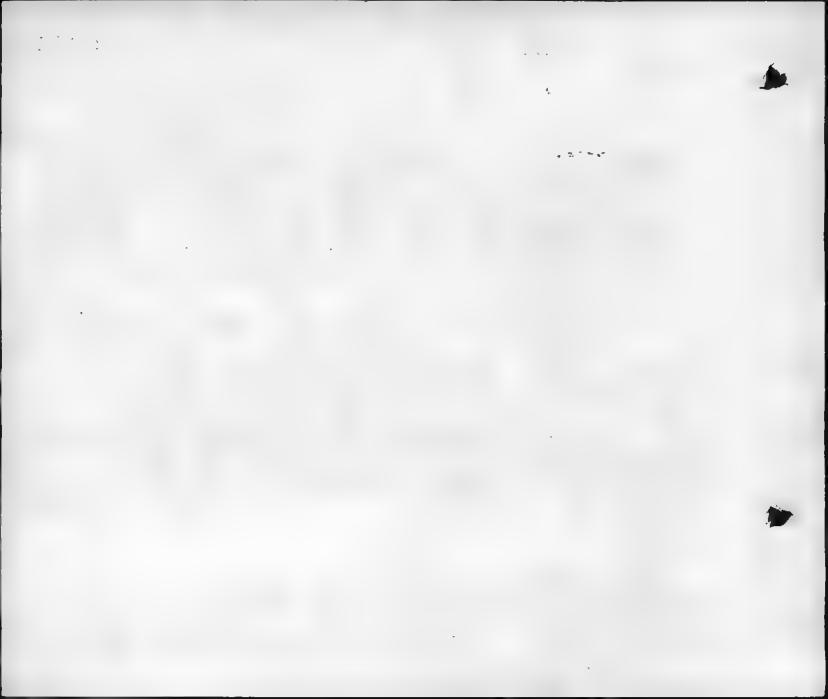
| Reg. Dist. | No. | 05 | 52 | 3 | 3 |
|------------|-----|----|----|---|---|
|            |     |    |    |   |   |

|     | 1.          | PLACE OF DEATH  o. COUNTY.   | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)  |
|-----|-------------|--|--|
| _   |             | Allegany   | o. STATE Maryland b. COUNTY Allegany   |
|     | F           | b. CITY OR TOWN (If outside corporate l'mits, write RURAL and give nedesti town)   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |
| 1/2 |             | Cumberland 16 days   | Cumber Land  |
|     | d           | d. NAME OF HOSPITAL OR INSTITUTION (finot in hospital, give street address)  | d STREET ADDRESS e IS RESIDENCE ON A FARM2   |
| ,   |             | Memorial Hospital  | 231 Race St. YES NO.   |
|     | 3. 1        | NAME OF First Middle   | Last 4. DATE Month Day Year  |
|     |             | (Type or print) Charles J. White   | DEATH May 1 1958   |
|     | 5. 5        | 6 COLOR OR RACE 7. MARRIED NEVER MARRIED 8.  |  |
|     |             | Male White WIDOWED TO DIVORCED   | March 8, 1868   90 yr.   1001   1001   1001  |
|     | 10o         | . USJAL OCCUPATION (G've kind of work done 10b. KIND OF BUSINESS OR INDUST during most of working life, even if retired) | RY 11. BIRTHPLACE (State or fore.gn country) 12 CITIZEN OF WHAT COUNTRY  |
|     | F           | Retired Conductor Railroad   | Mt. Lake Park, Md. USA   |
|     | 13.         | FATHER'S NAME  | 14 MOTHER'S MAIDEN NAME  |
|     |             | Bani White   | Sarah Caton  |
|     | 15.<br>Fřen | WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. IN  | (FORMANT Address   |
|     |             | no M   | iss Mary White, Cumberland, Md.  |
|     |             | 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]  | INTERVAL BETWEEN<br>ONSET AND GEATH  |
|     |             |  | Hemorrhage   |
| 1   |             | 4 or del DUE TO  | the control of   |
| Y   |             | Conditions, if ony, which) (b) Arteriosclero   | tic Cardiovascular Disease   |
| ~ / |             | gave rise to immediate cause (a), stating the underlying DUE TO  |  |
| -   |             | couse lost. (c)  |  |
| ių. | CATION      |  | OT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED?   |
|     | S           |  | e to fall from hemorrhage   YES   NO M   |
|     | CERTIF      | LERIMART LI DE CUNTRIBUTING ET   | nter noture of injury in Part I or Part It of item 18.)  |
|     |             | CAUSE OF DEATH. See above  | ALTERNATION OF THE PROPERTY OF |
|     | MEDICAL     | 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. #LAC While Not while foctor                               | CE OF INJURY (Home, farm, 20f. (City or town) (County) (State) iry, street, office bldg., etc.)  |
|     | ME          | p. m. 19 at work of work   |  |
|     |             | 21. I certify that I took charge of the remains described about  | ve, held an Autapsy 🔲, Inspection 🔀, Inquiry 💢, and in niy   |
|     |             | apinion deoth resulted from: Natural causes , Accident   | , Suicide , Homicide , Undetermined manner   |
|     |             | ACTUAL BILLY   | DATE SIGNED  |
| /)  |             | SIGNATURE D. Skilarelic  | M.D. CHIEF MEDICAL EXAMINER []   |
| d   |             | EXAMINER'S   | ASSISTANT MEDICAL EXAMINER   |
|     |             | NAME (TYPO) B. SKITARELIC  | DEPUTY MEDICAL EXAMINER  |
|     |             | BURIAL CREMATION 276 DATE THEREOF 22c. NAME OF CEMETERY OR   | (3,016)  |
|     |             | Burial 5-5-58 SS. Peter &  |  |
|     | 40.         | James F. Scarpelli, Cumberland   | Md 240 REGISTRAR 26 REGISTRAR'S SIGNATURE  |
|     |             | ounce to beet perses ouncersuit  | DATE   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, with 19 the word "pending" in pending in lem, 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forworded to "Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your fille.

TO FUNERAL DIRECTOR: 1 3 should be used as a buriol-transit permit. File pages 1 and 2 with the State Board of Herman is designated agent, prior to barial, cremation, or removal, and in any event within 72 hours after death.

**V5. A15ME** 5M 2 '57



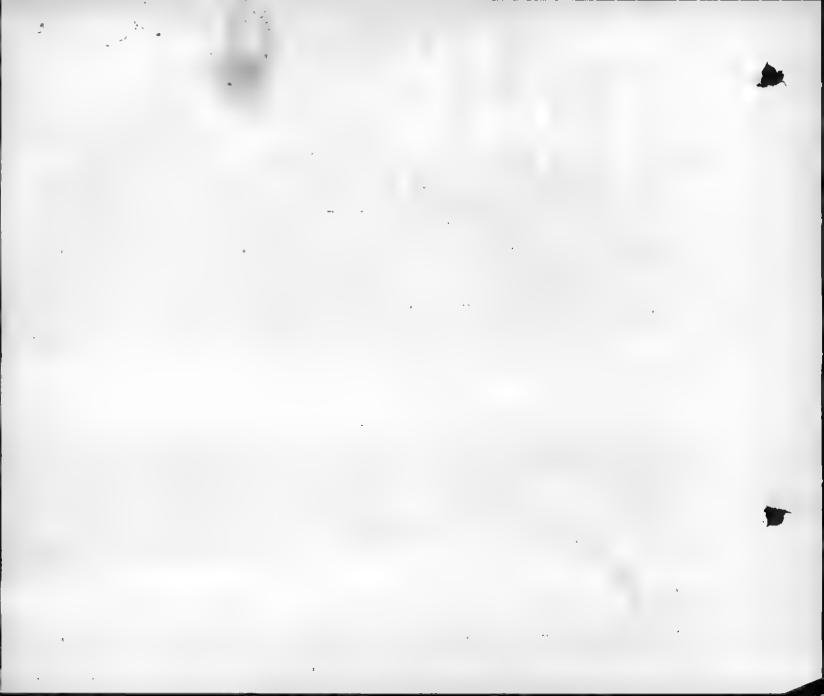
VS A15 (4) 15M 10/57 I

| MARYLAND | STATE DEPARTMENT | OF HEALTH—BALTIMORE, | 18 |
|----------|------------------|----------------------|----|
| F0.00    |                  |                      |    |

5238 CERTIFICATE OF DEATH

Reg. Dist. No. 05234

| 1    | . PLACE OF DEATH                           |  |                  |                    |             | 2. USUAL RESE        | DENCE (Wh      | ere decease   | d Irved If institut             |                | ce before o  | dmission)                 |
|------|--|--|------------------|--------------------|-------------|----------------------|----------------|---------------|---------------------------------|----------------|--------------|---------------------------|
| П    |  | egant  |                  |                    | MARYLAND    | 1                    | Marvl          | land          | b. COUNTY                       | lega           | mar          |                           |
| ľ    | b. CITY OR TOWN (IF RURAL and give nee     | outside corporale limitarest, town)                | ts, write        | c. LENGTH OF       | STAY IN 16  |                      |                |               | rate limits, write              | RURAL and g    | give nearest | lown)                     |
| L    | Frostb                                     |  |                  | Lifet              | ime         | Pros                 | Ehmes          | o'            |                                 |                |              |                           |
|      | d NAME OF HOSPITA<br>OR INSTITUTION        | L (If not in haspital, g                           | ive street o     | address)           |             | d STREET A           | DDRESS         | >             |                                 |                |              | S RESIDENCE<br>ON A FARM? |
|      |  | liners Ho  | ospi             | tal .              |             | 15 E                 | Mai            | n             |                                 |                | YI           | ES NO I                   |
| 3    | . NAME OF<br>DECEASED                      | Fir  | st               | ٨                  | Aiddle      | Los                  | if .           | 4. DATE<br>OF | Mo                              | nth            | Day          | Yeor                      |
|      | (Type or print)                            | RUTH   |                  | MART               | AN JE       |                      | LD             | DEATH         | S. 5                            |                | 15           | 19 58                     |
| , 4  | i. SEX                                     | 6. COLOR OR RACE                                   | 7 MARR           | IED NEVER A        | AARRIED 🔲   | B. DATE OF BIRT      | Н              |               | 9. AGE (In years last birthday) | IF UNDER       |              | UNDER 24 HRS.             |
| Т    | F.   | M.   | WIDOWE           | VIQ 🗂 0:V          | ORCED 🔲     | 5-20-0               | 9              |               | 48 yrs.                         | Months         | Days He      | outs Min                  |
| 1    | 0o USUAL OCCUPATION during most of working | N (Give kind of work on the life, even if retired) | dane 10b.        | KIND OF BUSIN      | ESS OR INDU | STRY 11 BIRTHPL      | LACE (Stote o  | or fareign c  | ountry)                         | 12 CIT         | IZEN OF W    | VHAT COUNTRY?             |
|      | Housewor                                   |  |                  | wn Home            | 3           | Midl                 | and.           | Md.           |                                 |                | II.S.        | Δ                         |
| ī    | 3. FATHER'S NAME                           |  |                  |                    |             | 14. MOTHER'S         |                |               |                                 |                |              |                           |
| L    | Alfred J                                   | effries  | ,                |                    |             | Reul                 | ah Wi          | leon          |                                 |                |              |                           |
|      | 5. WAS DECEASED EVER                       | IN U.S. ARMED FOR                                  |                  | SOCIAL SECURIT     | Y NO. 17. I | NFORMANT             | C-11 11.T      | TEOCH         | Ado                             | Iress          | Fros         | stour?.                   |
| ľ    | 2.7  | f yes, give war or dates of it                     | S.               | 18-34-2            | 2654 0      | eorge :              | F. Wh          | itef          | ield, Is                        | E. 1           | Mein         |                           |
| -    | NO LINE CALLER OF DEAL                     | None   |                  |                    |             | 2                    |                |               |                                 | 2014           |              |                           |
| П    |  | TH [Enter only one co<br>'H WAS CAUSED BY:         | use per lin      | e for (o), (b), on | d (c)-]     | 1                    | 0 -            | P             | 0 16.                           |                | ONSET,       | AL BETWEEN                |
|      | 331X                                       | IMMEDIATE CAUSE (6)                                | )                | <u> </u>           | 200         | relp                 | 200            | cycl          | and Xe                          | me who         | 2 4          | noulte                    |
|      | 12217                                      | DUE TO   |                  | Can 1              |             | - 0                  | 77.            | 1/            | 2 /                             | A- (           | 1 9          | 0-                        |
|      | Conditions, if on                          |  | 1                | CAVI               | eno         | sclert               | suc            | Vas           | cultyh                          | yea.           | 1 7          | CELIO_                    |
|      | gave rise to im                            |  |                  |                    | ,           |                      |                |               |                                 |                | 10           |                           |
| ı    | lying couse lost.                          | (c)  |                  |                    |             |                      | 1              |               |                                 |                |              |                           |
| 1    | PART II. OTH                               | ER SIGNIFICANT CON                                 |                  | ONTRIBUTING T      | O DEATH BUT | NOT RELATED TO       | THETERMIN      | NAL DISEAS    | E CONDITION GI                  | VEN IN PART    | 1(o) 19. V   | VAS AUTOPSY               |
|      | PART II. OTH                               |  |                  |                    |             |                      |                |               |                                 |                | P            | ERFORMED?                 |
| 1    | 20a ACCIDENT WAS                           | UNDERLYING [                                       | 20b. DESC        | RIBE HOW INJU      | JRY OCCURRE | D. (Enter noture o   | f injury in P  | art I or Por  | I II of item 18.)               |                |              | o Li moza                 |
|      |  | MEDICAL EXAMINER)                                  |                  |                    |             |                      |                |               | •                               |                |              |                           |
| 1    | 20c. TIME OF INJURY<br>Hour o. m.          | Month, Day, Yea                                    |                  | JURY OCCURRE       | D 20e. PL   | ACE OF INJURY (      | Home, form,    | 20f. (City    | or town)                        | (0             | ounty)       | (State)                   |
| 2014 | p. m.                                      | 19   | While<br>of work | Nat while of wark  | o   ™       | lory, silest, office | a blog , e.c., | 'i            |                                 |                |              |                           |
|      | 21. I certify the                          | at Lattended, the                                  | decease          | d from             | may         | 1959                 | to n           | vay,          | 15 195                          | that I I       | ast saw      | the deceased              |
|      | alive on m                                 | oy 14  | 12.5             | S and              | that death  | occurred at          | 3201           | No from       |                                 |                |              | stated above.             |
| ı    |  | 10   | ^                | ~                  |             | _                    |                | 400           | reet, city or town,             |                |              | DATE SIGNED               |
|      | ACTUAL<br>SIGNATURE                        | Jely   | 15,              | Dow                | ia,         | M.D                  | 2              | B             | ROAd                            | UAY            | 5            | 11.5/58                   |
|      | U  | _ ,  |                  | - 1                | /           | مسم                  |                | 11            |                                 | . /            |              | £6                        |
|      | PHYSICIAN'S<br>NAME (Type)                 | ohn 1  | 3,               | DAVI.              | S, MD       | +                    | 705/           | 64,           | RY, Mo                          | / _            |              |                           |
| 2    | 20. BURIAL, CREMAT ON                      | , 226. DATE THEREO                                 | F                | 22c. NAME OF       | CEMETERY O  | R CREMATORY          | 1              | 22d LOCA      | ION (City, town,                | or county)     |              | (Stote)                   |
|      | REMOVAL (Specify)                          | 5-17-58  | 3 5              | t. Mic             | chael       | s Ceme               | terv           | Fros          | tburg                           |                | *            | Id.                       |
| 2    | FUNERAL DIRECTOR'S                         | SIGNATURE HE                                       | fer              | FLAPPRESS (        |             |                      | 24a. REC'D     |               |                                 | STRAR'S SIG    |              |                           |
| 1    | sulah H. K.                                | Cultury 23   | 5 E.             |                    |             | urg,Md               |                |               |                                 | Leau           | 1            |                           |
| 4    |  |  |                  |                    |             | 0,1114               | MAN A          | 1 2 -         | 1 1 40                          | الماسين عرب ال |              |                           |



MEALTH DEPT. execute the certificate, withing the word "panding" in pencil in Item, 18. Give Pages 1, 2, and 3 to the funeral director. Sen execute the certificate, within the word "panding" in pencil in Item, 18. Give Pages 1, 2, and 3 to the funeral director. Sen 4 should be forwarded to be Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your filt.

TO FUNERAL DIRECTOR: For 3 should be used as a burial-transit permit. File pages 1 and 2 with the Slate Board of FIF or its designated agent, prior to burial, cremotion, or remayal, and in any event within 2 hours after death M execute the certificate, with the standard to the standard to

VS. ALSME \$M 2/57

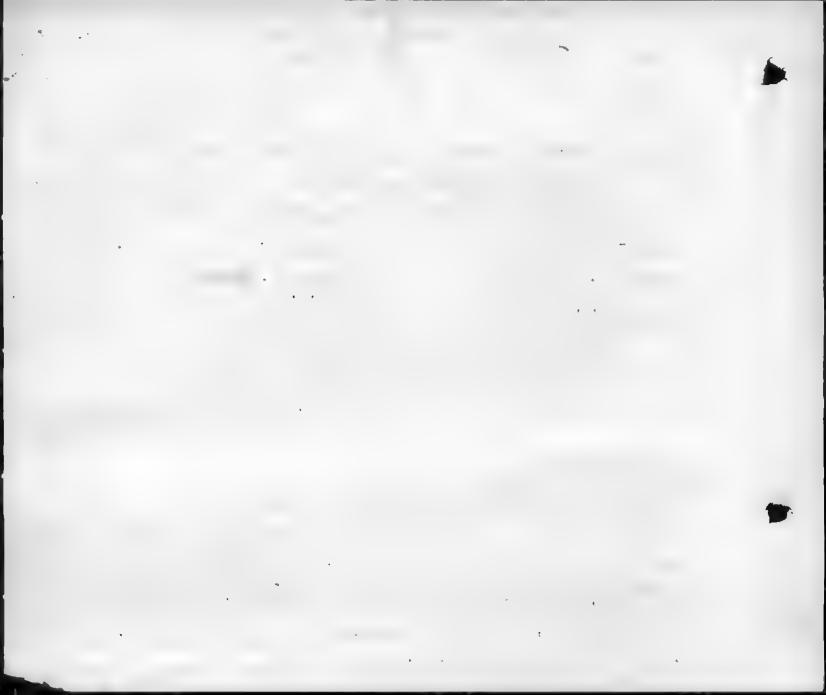
I

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 524 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05235

|   | The second secon | Reg. Dist. No.   |         |
|---|--|--|---------|
|   | 1. PLACE OF DEATH  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admissi | ion)    |
|   | IN COUNTY allegans MARYLAND  | o STATE Maryland b. COUNTY Allegany  |         |
|   | b. CITY OR TOWN (If out de conforcé limits and EURAL c. LENGTH OF STAY IN 16 and give necrest town)  | c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town    | 3)      |
|   | Rural near Lonaconing  | X Lenacening   |         |
|   | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)   | d. STREET ADDRESS e 15 hE"   | DENCE   |
|   |  | Castle Hill Yes  | NO A    |
|   | 3. NAME OF First Middle .  | Lost 4. DATE Month Day Yea   | )r      |
|   | (Type or print) Yames Francis Wh   |  | 58      |
|   | 5. SEX /6 COLOR OR RACE 7. MARRIED NEVER MARRIED 8.  | DATE OF BIRTH  9. AGE (In years) IF UNDER TYEAR IF UNDER to thinday)               | 24 HRS  |
|   | Male White WIDOWED   DIVORCED  | Jan, 30, 1921 37 yrs. Months Days Hours  | Min,    |
|   | 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUST) during most all working life, even if retired)  | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT CO                   | OUNTRY  |
|   | LABORER COUSTRUCTION   | LONGCONING Md. LV, S.A.  |         |
|   | 13. FATHER'S NAME  | 14. MOTHER'S MAIDEN NAME   | 1       |
|   | Simon Whiteman   | Hattie Ailler  |         |
|   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. IN  | FORMANT Address  |         |
|   | (10s. no. of unknown) (11 yes, give wor or dates also yes) 212-18-1524 3/17  | s. James Whiteman Lonaconing, M  | 6       |
|   | 15/CAUSE OF DEATH [Enter only one cause per l'ine for (a), (b), and (c).]  | IIIVI for  | · ·     |
|   | PART I, DEATH WAS CAUSED BY:   | ONSET AND GEATH  |         |
|   | 9/2./ IMMEDIATE CAUSE (a) CALLONICAL CA  | vest suare   | برارا   |
|   | Condo +  |  |         |
|   | gave rise to immediate couse   |  |         |
| į | (a), staling the underlying DUE TO   |  |         |
|   |  | OT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19, WAS AU         | ATOREY. |
| . | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO  200. EXTERNAL CAUSE WAS  RIMARY TO CONTRIBUTING CONTRIBUTING CAUSE OF DEATH  CAUSE OF DEAT | PERFORM  | MED3    |
|   | H 200 PYTERNAL CALLES WAS 200 DESCRIBE HOW INVERSE OF THERE IS   | YES 1  | NO D    |
|   | PRIMARY TO OF CONTRIBUTING CAUSE WAS CAUSE OF DEATH.   | are native at injury in rort of rort (1 of them 18.)                               |         |
|   | 3 20c. TIME OF INJURY Month, Day, Year 20d, INJURY OCCURRED 2 PLACE  | ( Jarm)  |         |
|   | O Hour While Not while   | E OF INTORY (Home, farm, 120f. (City or town) ry, street, affice bldg., etc.)      | (Stole) |
|   |  | tarm Lonaconing alleg. V   | nd      |
|   | 21. I certify that I tolk charge of the remains described above  | e, held an Autopsy, Inspection   | m my    |
|   | opinion death resulted from: Natural causes [], Accident [   | , Suicide , Homicide , Undetermined manner   |         |
|   | A : 40:  | DATE SIG   | SUETI   |
|   | SIGNATURE / Denedict Sketarelia  | M.D. CHIEF MEDICAL EXAMINER  | HAED    |
| , | EXAMINER'S 12  | ASSISTANT MEDICAL EXAMINER D May 10, 195   | .0/     |
|   | NAME (Type) Denedict SKITARELIC  | DEPUTY MEDICAL EXAMINERS May 10, 195   | 0       |
|   | 220. BURIAL CREMATION, 226 DATE THEREOF 22c NAME OF CEMETERY OR  |  |         |
|   | BUYTET 5/13/58 Memerial Pa   | rk Frostburg, Ma.  |         |
|   | 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS   | 240 REC'D SY REGISTRAR 246. REGISTRAR'S SIGNATURE                                  |         |
| i | George Eichhorn Lonacening, M  | DATE MAY 15 '58 COM BUILD  |         |
|   |  |  |         |





|     |    |     | •  | AG ( | 1   |
|-----|----|-----|----|------|-----|
|     | FO | R   | ST | AT   | E   |
| H   | EA | LTI | H  | DE   | PT. |
| 926 |    |     |    |      | -   |

DEPUTY MEDICAL EXAMINER: This certificate should be uxecuted within 24 hours after death. If any delay is necessary, ples execute the certificate, with a hord "pending" in pendi in them. 18. Give Pages 1, 2, and 3 to the funeral director. Pages the forwarded the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your filty FUNERAL DIRECTOR: hage 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of He or its designated agent, prior to berial, cremotion, or removal, and in any event within 72 hours after death.

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| VS. | A1 | SME |
| 4,6 | 12 | 57  |

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, | 18             |    |
|--|----------------|----|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH        | Reg. Dist. No. | () |

| 5227 MEDICAL EXAMINER'S  | S CERTIFICATE OF DEATH  Reg. Dist. No. (15237)   |
|--|--|
| 1 PLACE OF DEATH   | 2. USUAL RESIDENCE (Where deceased lived. It institution Residence before admiss on)   |
| a. COUNTY Allegany MARYLAND  | o. STATE Maryland b. COUNTY Allegany   |
| b. CITY OR TOWN   f outside corporate limits, write BURAL c. LENGTH OF STAY IN 16 and give hoorest fown)               | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |
| Cumberland 21 years  | 02Cumberland   |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospito), give street oddress)  | d STREET ADDRESS 6 S. REC'DENCE ON A FARME.  |
| Memorial Hospital  | 156 Frederick Street YES NO 2  |
| 3. NAME OF DECEASED First Middle   | Last 4. DATE Month Day Year  |
|  | ilson May 26 19 58   |
| 5. SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED 1  | DATE OF BIRTH  9. AGE HIS YOURS  Set brillholds)  Months  Doys  Hours  M.n.  |
| Male White WIDOWED DIVORCED 100. USUAL OCCUPAT ON (Give kind of work done 10b KIND OF BUSINESS OR INDUS                | August 25 1936 21 m  |
| during most of working life, even if retired)  | 12. CHIZER OF WAXI COURTE  |
| Student - Business college.  | Maryland U. S.   |
| W. Harvey Wilson   | Sarah Davis  |
| 15. WAS DECEASED EVER IN U. S ARMED FORCES? 16 SOCIAL SECURITY NO 17. I  | NFORMANT Address   |
| Yes 1955 to 1957 218-34-4984   | Mrs. Shirley Tomsko LaVale, Md   |
| 18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]   | INTERVAL SETWERN ONSET AND DEATH   |
| PART I. DEATH WAS CAUSED BY: Intracrania:  | 1 Hemorrhage   |
| 816 X DUE TO   |  |
| Conditions if ony, which (b) Skull F:  | racture 3 hrs.   |
| gove rise to immediate cause Que TO  |  |
| couse last. (c)  |  |
| СТРО   | NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19, WAS AUTOPSY PERFORMED? YES X NO   |
| 200. EXTERNAL CAUSE WAS PRIMARY BY OF CONTRIBUTING □ CAUSE OF DEATH.  20b DESCRIBE HOW INJURY OCCURRED. ( Auto bus col | Enter nature of injury in Part I or Part II of Itom 18.)   |
| 1  | CE OF INJURY (Home, form, 120f (City or town) (County) (State)   |
| To Hear 2016 _ /   While Not while 1 loca  | ory, street, office bldg etc.) Street Cumberland, Alleg. Md.   |
| 21 I certify that I took charge of the remains described abo   |  |
| opinion death resulted fram. Natura causes . Accident  |  |
| 2 11/01/21   |  |
| SIGNATURE Devedect Sketatelic _  | M.D., CHIEF MEDICAL EXAMINER []  |
| EXAMINER'S Deposit of Sintensity   | ASSISTANT MEDIÇAL EXAMINER   |
| NAME (Type)  Benedict Skitarelic, M. 1  220. BURIAL, CREMATION, 172b. DATE THEREOF  220. NAME OF CEMETERY OF           | The state of the s |
| REMOVAL (Specify)  | 36   |
| Burial 5/29/58 Mt Herman 23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS   | Cemetery Cumberland Maryland -   |
| Ruth E. Silcox Cumberland, Ma  | ryland DATE MAY 2 9 '58 \ Cio eauch  |



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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05238

|       |                                    | 5228                                 |  |   |          |  |                         |              |  | Reg. I   | Pist. No          |          |   |
|-------|------------------------------------|--------------------------------------|--|---|----------|--|-------------------------|--------------|--|--|-------------------|----------|---|
|       | PLACE OF DEATH                     | 7.050                                |  |   |          | 2. USUAL RESIDE                        | ENCE (W                 | here deceo   | ed lived. If institu                   | plion: Resid   | ience bel         | ore odm  | ission)                                 |
|       | a. COUNTY A 7 7 P                  | gany                                 |  | MARY                                      | LAND     | a. STATE THE                           | TIO                     |              | b. COUNT                               | Y 164.   | 0.000             | . 7      |   |
| -     |                                    | Ulside corporate limits, write #UE/  | L)   | c. LENGTH OF STAY                         |          | CITY OF TO                             | Va                      | entries con  | parate limits, write                   |  | nera              |          | wn)                                     |
| 1     | and give nearest fawn)             |                                      |  |   |          |  | _                       |              |  | NUNNE OF   | a Bise ii         | BUIGH TO | arity .                                 |
| _     | Cumber.                            |                                      |  | 10 minu                                   |          | Route                                  | -                       | Rid          | geley                                  | X  | X                 | 1        |   |
|       |                                    | L OR INSTITUTION (If not             | in hospi   | ital, give street addres                  | (a)      | d. STREET ADE                          | PRESS                   |              |  |  |                   |          | A FARM?                                 |
|       | Memoria.                           | l Hospital                           |  |   |          |  |                         |              | ** ** ******************************** |  |                   | YES [    | ] NO [                                  |
| 3,    | NAME OF<br>DECEASED                | First                                |  | Middle                                    |          | Last                                   |                         | 4. DATE      | Mant                                   | h  | Day               | Y        | fear                                    |
|       | (Type or print)                    | John                                 | M  |   |          | Wolfe                                  |                         | DEATH        | May                                    |  | 11                | 1        | 1958                                    |
| 5. 5  | SEX                                | 6. COLOR OR RACE 7.                  | MARRIED  | NEVER MARRIE                              | 8.       | DATE OF BIRTH                          |                         |              | 9. AGE (In years                       | IF UNDE  | TYEAR             |          | ER 24 HRS                               |
|       | Male                               | White wa                             | DOWED  | DIVORCED                                  | o J      | uly 14.                                | 193                     | 9            | 18 yrs.                                | Months   | Days              | Hours    | Min.                                    |
| 100   | usual occupation                   | (Give kind of work done              | 10b. KI  | ND OF BUSINESS OR                         | INDUSTR  | Y 11. BIRTHPLACE                       | E (Stole                | or foreign c | ountry)                                | 12. CI   | IZEN O            | TAHW     | COUNTRY                                 |
| ,     | Clerk                              | ing, gran is remed;                  | Pro  | oduce Hou                                 | ise      | Vir                                    | gin                     | ia           |  |  | USA               | 1        |   |
| 13.   | FATHER'S NAME                      |                                      | 40   | 74400 1100                                |          | 14. MOTHER'S MA                        | -                       |              |  | -  | 002               |          |   |
|       | William                            | u Wolfe                              |  |   |          |  | Q+                      | 0770         | Davids                                 | 030  |                   |          |   |
| 15.   | WAS DECEASED EVER                  | H. WOLIE                             | 2 116 5  | OCIAL SECURITY NO.                        | 17 IN    | FORMANT                                | 00                      | CTTG         | Address                                |  |                   |          | -                                       |
| {Yes  | a, no. or unknown)                 | If yes, give war or dates al service | 1  |   |          |  | ~1.0                    | o 0:         |  |  | T                 | 7.0      |   |
|       | No                                 |                                      |  | 26 50 373                                 | עי       | W. H. W                                | OTI                     | e, 52        | r. Cate                                | CIL  |                   | /a.      |   |
|       |                                    | i [Enter anily one cause pe          | er line to   | or (o), (b), and (c).                     |          |  |                         |              |  |  | ONSE              | T AND DE | EEN<br>ATH                              |
|       | PARI I. DEATH                      | MAS CAUSED BY:                       | Fra  | cture Ce                                  | rvio     | cal Ver                                | tebr                    | 286          |  |  | S                 | udd      | en                                      |
|       | 825×                               | DUE TO                               |  |   |          |  |                         |              |  |  |                   |          |   |
|       | Conditions, if any                 | y, which } (b) ~                     | Ant  | omobile .                                 | Agas     | dent                                   |                         |              |  |  | 1                 |          |   |
|       | gave rise to immedia               | ate cause                            |  |   |          | W. W. A. A. W.                         |                         |              |  | ~  |                   | -        | * |
|       | (a), stating the un<br>cause last. | (c)                                  |  |   |          |  |                         |              |  |  |                   |          |   |
| Z     | PART II, OTHE                      | R SIGNIFICANT CONDITIO               | NS CON   | TRIBUTING TO DEAT                         | H BUT N  | OT RELATED TO TH                       | E TERMII                | NAL DISEAS   | E CONDITION GIV                        | VEN IN PA  | RT 1(o) 1         | 9. WAS   | AUTOPSY                                 |
| ATION |                                    |                                      |  |   |          |  |                         |              |  |  |                   | PERFO    | RMED?                                   |
| 5     | 200. EXTERNAL CAUS                 | E WAS 1204 DE                        | CCOME  | HOW INDIBA OCCU                           | DED /E-  | the entire of false                    | T. Beat                 | 1 - 0 - ( 1) | -61101                                 |  |                   | YES [_]  | NO 📑                                    |
| ERT   | PRIMARY D or CONT                  | RIBUTING [                           | SCRIBE   | HOW INJURY OCCUI                          | KED. JET | ner noture of injury                   | r in ran                | 1 of Port II | or item 19.)                           |  |                   |          |   |
| 0     |                                    |                                      | of the latest states and the latest states a | the state of the state of delates and the |          | Ident                                  |                         |              |  |  |                   |          |   |
| Š     | 20c. TIME OF INJURY                | Month, Day, Year                     | 20d. in<br>While   | Nat while                                 | De. PLAC | E OF INJURY (Honey, street, office blo | ne, form,<br>de., etc.) | 20f. (Cil)   | or town)                               | {Ce  | runty)            |          | (Stote)                                 |
| MEDI  | 1 24                               | 5/4/58 19                            | of work  |   |          | street                                 |                         |              | dgely,                                 | Mine   | ral               | . W      | .Va.                                    |
|       | 21. I certify the                  | at I took charge of                  | the re   | emoins describe                           | d abov   | re, held an A                          | utopsy                  | ( ), h       | ispection ,                            | Inqui  | ry 🖪              | an       | d in my                                 |
|       | opinion death re                   | esulted from: Nati                   | urphod   | ouses . Accie                             | dent [   | , Suicide [                            | ], H                    | łomicide     | . Undete                               | rmined   | manne             | er 🔲     |   |
|       | 1                                  | - 1                                  | V.   |   | ,        |  |                         |              |  |  |                   |          |   |
|       | SIGNATURE                          | nedecto                              | 16   | Jakolia                                   | 1        | M.D. CHIEF MED                         | ICAL EX                 | AMINER [     |  |  |                   | DATE S   | HIGNED                                  |
|       | 702                                |                                      | 7,-  |   |          | ASSISTANT                              | MEDICA                  | L EXAMINE    |  | 4  |                   |          |   |
|       | EXAMINER'S B                       | enedict Sk                           | ita  | relic                                     |          | DEPUTY ME                              | DICAL E                 | XAMINER [    | <b>季</b> 5/4                           | 1/58   |                   |          |   |
| 220   | BURIAL CREMATION                   | 226. DATE THEREOF                    | 12   | TOO. NAME OF CEMET                        | ERY OR   | CREMATORY                              |                         | 22d. LOCA    | TION (City, fown,                      | or county)   |                   | (51 at   | •)                                      |
|       | Burial                             | May 7,195                            | 8  | Holston                                   | Vie      | w Cemet                                | ery                     | W            | eber Ci                                | ty,  | Va.               |          |   |
| 23.   | FUNERAL DIRECTOR'S                 |                                      |  | ADDRESS                                   |          |  |                         | BY REGIST    | RAR 24b. REGIS                         | STRAR'S SI   | GNATUR            | E        |   |
| J     | . E. Boil                          | hnott G                              | ate  | City, Va                                  | lo       | D.                                     | ATEMA'                  | Y 6 15       | 58 Cle                                 | Len  | ich               |          |   |
| -     |                                    |                                      | The second second  |   |          | -                                      | _                       |              |  | The state of the last of the l | The second second |          |   |

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A DEPUTY MEDICAL EXAMINER: This certificate shared be executed within 24 hours after death. If any delay is necessary please execute the certificate, within 1 he word "pending" in penal in Nem 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded 1. Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file 10 FUNERAL DIRECTOR: Page 3 should be used as a buriot-transit permit. File pages 1 and 2 with the State Board of Heren or its designated agent, prior to buriot, cremation, at removal, and in any event within 72 hours after death.

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|               |                   | . W . 1919 M    | me officer    |       |

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